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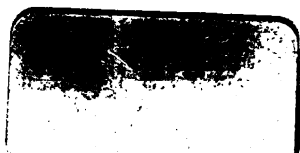
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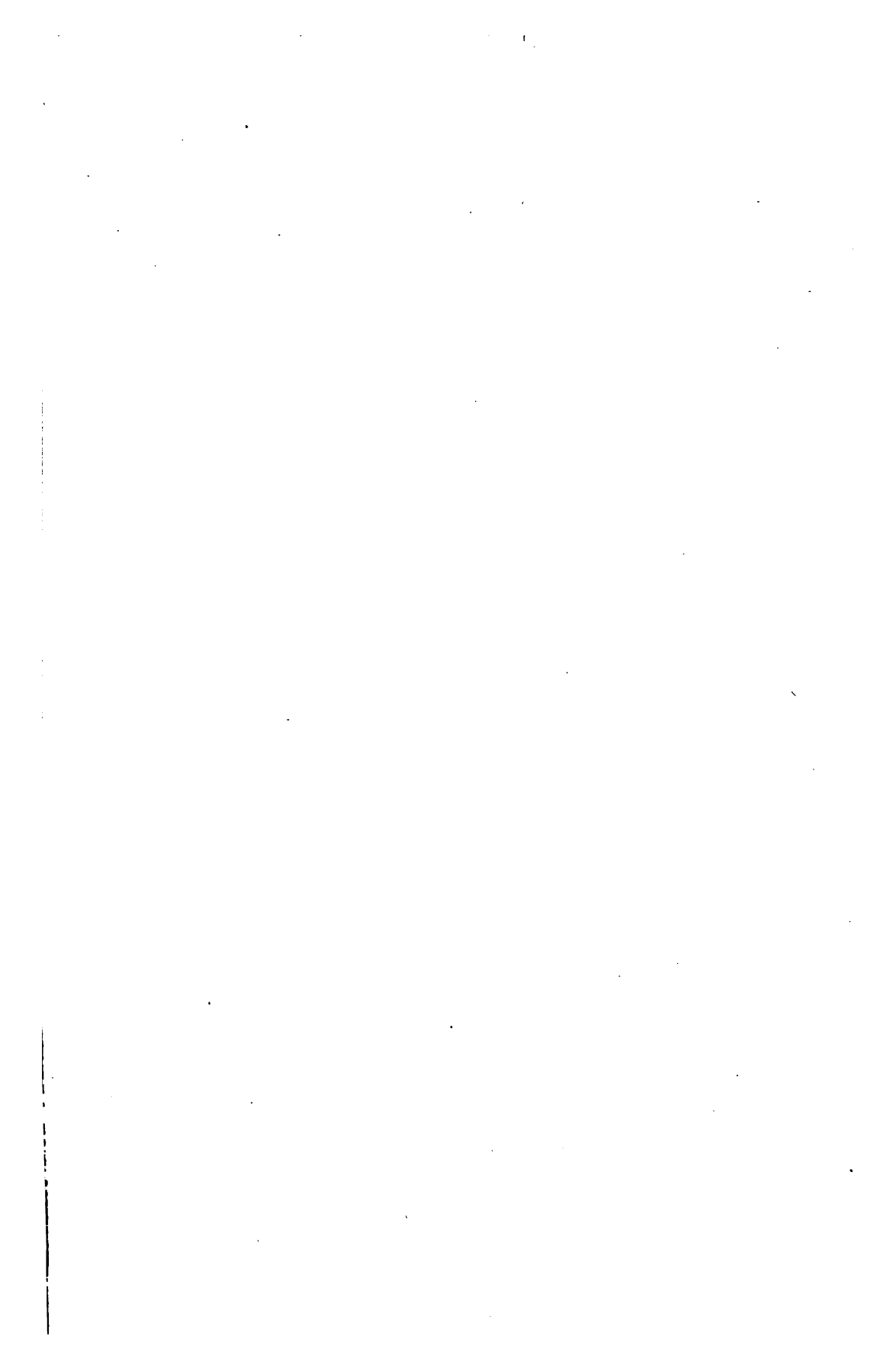
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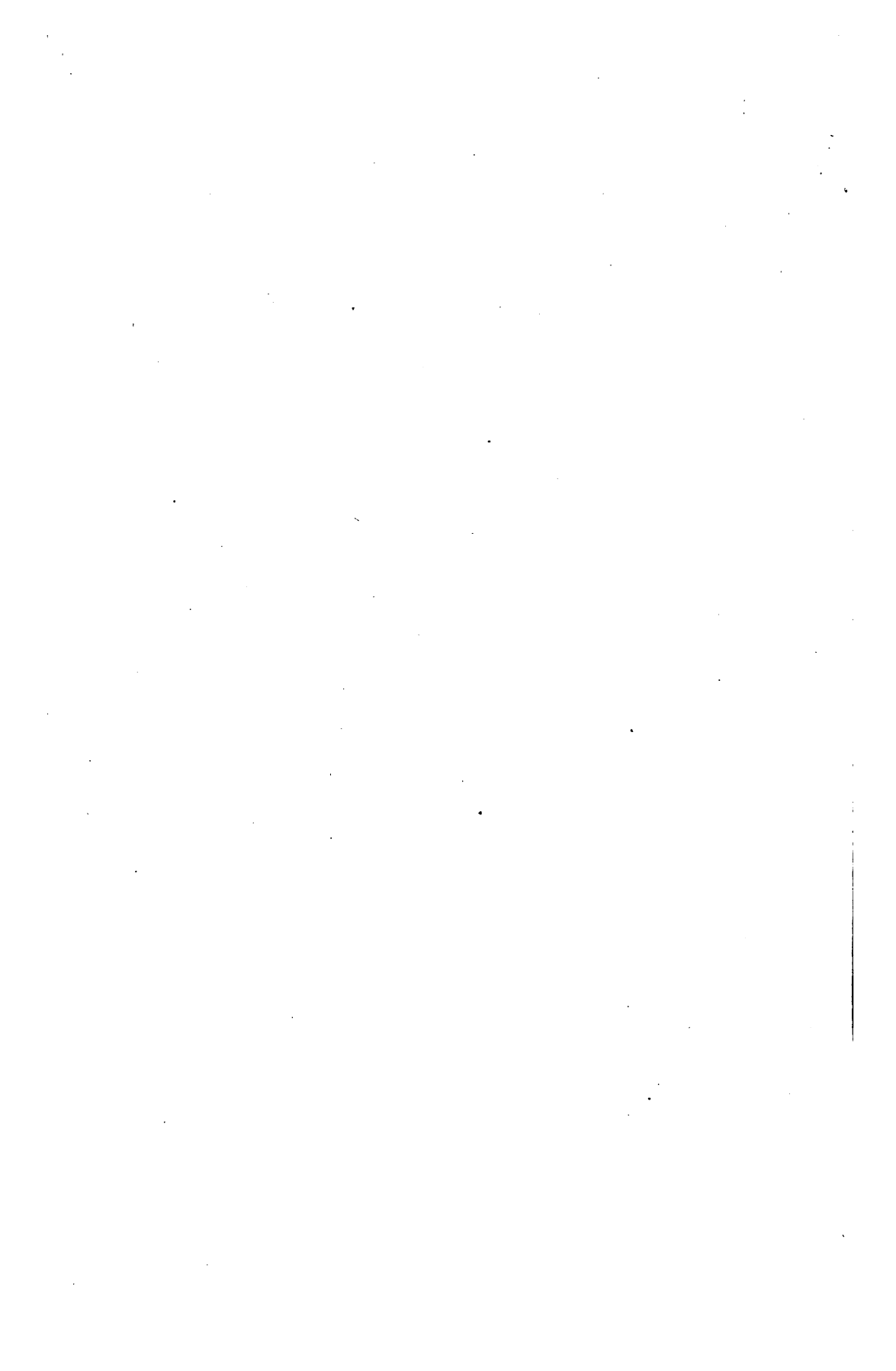
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PROCEEDINGS  
OF THE  
NEW YORK  
PATHOLOGICAL SOCIETY

FOR THE YEAR 1893



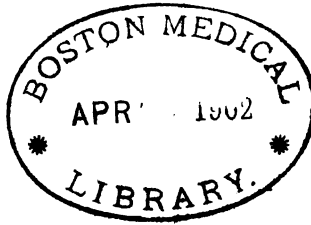
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ORGANIZED IN 1844

INCORPORATED IN 1886

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PRINTED FOR THE SOCIETY  
1894



2815

The Knickerbocker Press  
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NEW YORK





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| *Dr. JOHN A. SWETT,          | 1844             |
| *Dr. WILLARD PARKER,         | 1845, 1846, 1847 |
| *Dr. JAMES R. WOOD,          | 1848, 1857       |
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| *Dr. W. H. VAN BUREN,        | 1850             |
| *Dr. CHARLES E. ISAACS,      | 1851             |
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| *Dr. HENRY VAN ARSDALE,      | 1853             |
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| *Dr. GURDON BUCK,            | 1865             |
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| Dr. JOHN A. WYETH,           | 1885, 1886       |

\*Deceased.

|                          |            |
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| Dr. T. MITCHELL PRUDDEN, | 1887       |
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| *Dr. HENRY G. COX,                        | 1850 to 1852 |
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| *Dr. CHARLES M. ALLEN,                    | 1852 to 1853 |
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| *Dr. J. FOSTER JENKINS,                   | 1854 to 1855 |
| *Dr. E. LEE JONES,                        | 1855 to 1861 |
| Dr. T. GAILLARD THOMAS, <i>pro tem.</i> , | 1855         |
| Dr. HENRY D. NOYES, <i>pro tem.</i> ,     | 1858         |
| Dr. GEORGE F. SHRADY,                     | 1861 to 1879 |
| *Dr. WESLEY M. CARPENTER,                 | 1880 to 1888 |
| Dr. WALTER MENDELSON,                     | 1889         |
| Dr. T. L. STEDMAN,                        | 1889 to 1891 |
| Dr. OGDEN C. LUDLOW,                      | 1891 to      |

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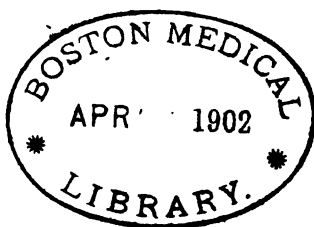
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- |                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                              |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
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|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

\*Deceased.





PROCEEDINGS  
OF THE  
NEW YORK PATHOLOGICAL SOCIETY.

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*Stated Meeting, January 25, 1893.*

DR. R. H. SAYRE, VICE-PRESIDENT.

HÆMATOMA OF THE DURA MATER.

DR. WILLIAM G. LE BOUTILLIER presented a brain showing a hæmatoma of the dura, which covered a large part of the convex surface of the left hemisphere, and which measured, in the fresh state, two inches in diameter and one half inch in thickness in its central portion. It had been removed from a man seventy-two years of age, who died after being in the hospital only two days. There had been no paralysis; he had only complained of feeling weak. The hemorrhage was the result of a chronic pachymeningitis.

CARCINOMA OF THE PANCREAS.

DR. LE BOUTILLIER then presented a specimen from a woman seventy-three years of age, who was admitted to the almshouse on December 28th, and died on January 2d. When admitted, there was slight cough, anæmia, and marked jaundice. Physical examination showed two tumors in the abdomen; one hard, movable, about two inches in diameter, and situated midway between the umbilicus and the anterior superior spinous process of the ilium,

and the other very solid, slightly movable laterally, and lying in the epigastrium and left hypochondrium. The patient had only a slight elevation of temperature— $100^{\circ}$  F.,—but she was greatly prostrated and refused food. The tumor on the right side was found to be a dilated gall-bladder, which contained a gall-stone and a somewhat turbid fluid, looking like pus. The other tumor proved to be the pancreas, which contained two carcinomatous masses. The cystic and common ducts were also dilated, and contained the same kind of fluid. The orifice of the common duct was surrounded by a dense growth in the head of the pancreas, and its orifice was obliterated. There were numerous enlarged lymph nodes behind the pancreas.

#### DOUBLE HYDRONEPHROSIS FROM CARCINOMA OF THE BLADDER.

DR. LE BOUTILLIER also presented a specimen which had been removed at an autopsy on a woman thirty-five years of age. A complete history of her previous condition could not be obtained, but it was learned that there had been for some time previous a vesico-vaginal fistula, and that she had been subjected to the operation of suprapubic cystotomy. There had been occasional profuse hemorrhages. Towards the end of last December, there was emaciation and gradual loss of strength, with headache, delirium, but with little elevation of temperature, and a diminution in the quantity of urine. She died on January 19, 1893, and an autopsy was held on the following day. The pelvis was alone of interest. The bladder, uterus, and its appendages, were all firmly matted together; both ureters were dilated at the crest of the ilium, the right measuring eighteen millimetres, and the left fourteen millimetres; they were filled with transparent urine, and both were bent upon themselves. There was a condition of hydronephrosis of both kidneys, but it was more advanced in the left. The bladder wall was the seat of a carcinomatous deposit, which had caused obstruction of both ureters, but the left ureter had been reopened by ulceration. There were secondary deposits in the left psoas muscle and in the right of the pelvis, as well as slight enlargement of the posterior gland.

Dr. S. T. Armstrong remarked that it was possible that temporary relief could have been obtained, and life prolonged, had the operation of transplanting the ureters into the rectum been performed.

## A GUMMA OF THE BRAIN.

DR. C. E. BRUCE presented a brain which had been removed from a man thirty-one years of age, whose family history was negative, and who denied having had syphilis. He enjoyed good health up to April, 1890, when he first sought medical advice because of an acne of the face. In July of the same year, he was suddenly seized with facial paralysis in all the branches of the facial nerve. In March, 1891, there was a return of the paralysis, associated with ocular disturbance, and an examination made at that time by Dr. David Webster showed a hemorrhagic retinitis. His facial paralysis was relieved by the administration of large doses of iodide of potassium, but this was only very temporary, for shortly afterwards there was a third attack of paralysis, from which permanent relief was not obtained. During the summer of 1891, he had much difficulty in breathing, his pulse was weak and dicrotic, and he had swelling of the feet and pains in the limbs, which did not yield to the usual antirheumatic remedies, but were relieved by the administration of iodide of potassium. Shortly after this, he began to have certain hallucinations. Last November he suffered a relapse of the facial paralysis, associated with loss of vision in the right eye, and diminution of vision in the left. His right eye was much congested and bulging; there was no paralysis of the tongue, but he had a staggering gait, and showed a want of co-ordination, and complained of much pain in the back of the head and neck. The pulse was weak, the breathing difficult, and the temperature normal, and the urinary examination negative. His hallucinations became greatly aggravated at this time. Dr. Webster found, on December 25th, an unusually abundant hemorrhagic retinitis of both eyes, and suggested the use of the oleate of mercury, which was tried, but without producing any notable effect on the progress of the disease. The patient died on January 20th, with symptoms of cerebral compression. A post-mortem examination was made of the brain only. The dura mater was found intensely thickened and closely adherent to the brain surface along the longitudinal fissure; there were several large serous cysts of the pia mater over the left frontal and temporal lobes; there was considerable fluid in the ventricles, and there were evidences everywhere of an extreme degree of atheroma. In the left optic thalamus and corpus striatum was a firm, dark mass, which proved on microscopical examination to be a gumma.

## NODULES OF CARCINOMA AND ADENOMA IN THE SAME LIVER.

DR. H. S. STEARNS presented a liver removed from a man fifty years of age, who died on the fifth day of a lobar pneumonia. The liver showed eight or nine small, round, white nodules, the largest one perhaps one and one half centimetres in diameter, situated directly beneath the capsule of the organ, and extending into its substance. Examination of sections showed in certain areas adenomatous tissue, and in others directly alongside of it, typical carcinomatous alveoli very much compressed. There were no other evidences of carcinoma. A number of suggestions were made as to the nature of these deposits, but it was not until they had been examined microscopically that it occurred to any one who saw them that they were carcinomatous.

## PERICARDITIS WITH MUCH FIBRINOUS EXUDATION AND THICKENING.

DR. STEARNS also exhibited a specimen from a case of pericarditis. The patient had been for several years past a night-watchman in Charity Hospital, and had been in good health up to a month ago, when he began to suffer from orthopnœa, and the lower extremities became œdematous. He passed sixty ounces or more of urine daily, having a specific gravity of 1028. Three days ago, he suddenly died while at stool, and an autopsy showed the apices of both lungs to be completely solidified with old tubercular deposit which had not ulcerated, and an accumulation of fully eight ounces of fluid in the pericardial sac. The chief points of interest were the marked thickening of the pericardium, and the abundance of fibrinous exudation.

## RUPTURE OF THE LIVER.

DR. E. HODENPYL presented a specimen of rupture of the liver, which had been removed from a woman who had committed suicide by throwing herself out of a fourth-story window. At the autopsy, made two hours after death, and six hours after the receipt of the injury, comminuted fractures of the ninth and tenth dorsal vertebræ were the only fractures which could be discovered, and they had led to hemorrhage into the pleural cavity, so that each cavity contained about one quart of blood. The abdominal

cavity contained about three quarts of fluid blood. All of the organs were normal except the liver, which exhibited an extensive laceration of its left lobe, apparently the result of simple compression. There were no marks of violence on the external surface of the body.

A THICKENING OF THE INTESTINAL WALL RESEMBLING  
CARCINOMA.

DR. HODENPYL exhibited under the microscope a section of intestinal wall which resembled very closely the structure of carcinoma. The specimen had been removed from a man who died of delirium tremens shortly after admission to the hospital, so that no history was obtainable. On opening the abdomen, the intestines were found firmly matted together everywhere by old, firm, fibrous adhesions; the great omentum was shrivelled up to a small cord, and the lumen of the gut was here and there so encroached upon as to hardly admit an ordinary lead pencil. The extrusion of particles of fat through these bands of fibrous tissue presented at first glance an appearance not unlike that of colloid carcinoma. The specimen was taken from the outside fibrous coat of the intestine near the attachment of the mesentery, and showed little spaces filled with large, flat cells, and well marked alveoli. On first thought, he considered the case one of carcinoma, but on further consideration, he had come to the conclusion that the appearance presented under the microscope was due to a proliferation of the endothelial cells.

ASPERMIA.

DR. F. TILDEN BROWN exhibited a specimen of abnormal seminal secretion without the elements from the seminal vesicles or the testicles. The fluid contains fatty granules, epithelial cells, small hyaline cells, and the corpora amylacea, and notwithstanding that it was the secretion from the prostatic urethra, it possessed the characteristic odor of the normal semen. The specimen was from a man thirty-four years of age, who had been married seven years. His wife had been examined, but no cause for sterility was found in her. He had had his semen examined by one or two physicians, but the reports regarding the existence of spermatozoa were conflicting. Nine years ago he had had a slight urethral discharge following sexual exposure, but it had

subsided in a very short time, and the physician who attended him then expressed the opinion that it was not a gonorrhœa. He had not had epididymitis or orchitis, or any traumatism of the perineum or testicles, and an examination of the external genitals showed them to be apparently normal. The speaker said he had been unable to find any spermatozoa. There was apparently a congenital occlusion of the ejaculatory duct.

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*Stated Meeting, February 8, 1893.*

DR. H. P. LOOMIS, PRESIDENT.

DESTRUCTION OF A PORTION OF THE OPTIC LOBE SECONDARY TO  
AN OLD CORTICAL HEMORRHAGE.

THE PRESIDENT exhibited a brain which had just been removed from a woman, aged sixty, who was admitted to the Almshouse Hospital, B. I., as an inmate of the "blind ward," February 29, 1892. The patient was apparently slightly demented, could give no history of herself, nor could she tell where she was. She talked incessantly, but at random, using exceptionally good language, and was apparently a person of education. Insomnia was a constant symptom. There was no paralysis nor interference with locomotion.

The external appearance of the eye was normal: there was slight nystagmus. There did not appear to be complete loss of vision, for, on a bright day, out of doors, she could tell when persons stood in her neighborhood. While in the ward, she would stare about without apparently seeing anything.

After being in the hospital nearly a year, and remaining in the same condition, she developed a chronic diarrhœa, and died at the end of three weeks.

The *autopsy*, which was made thirty-six hours after death, revealed no lesion of any organ except the brain, which presented the following appearance: The middle and inferior convolutions of the occipital, and the posterior portion of the inferior convolution of the temporal lobe of the right hemisphere had entirely disappeared, apparently atrophied. In the centre of the pia-mater, which covered over the depression caused by the

loss of brain substance, was a soft, brownish, encysted mass, the size of a small olive, which contained some cheesy material, in which were found crystals of cholesterine. The brain substance surrounding the destroyed area was normal in appearance and color. There was also a softened area, about an inch in diameter, over the parietal lobe (supra-Sylvian convolution) on the right side. With these exceptions, the brain was normal, and the arteries showed no evidence of disease. The dura mater was somewhat thickened over the atrophied area.

The conclusion reached from a study of the case is that, a year or more before the patient's death, there had been a cortical hemorrhage over the occipital lobe, probably of traumatic origin, which by pressure had in time atrophied the underlying brain tissue. The clot finally became encysted, and resulted in the cheesy mass found. The case is interesting as showing, by the limited lesion found, and the eye symptoms present during life, that the localization of the sight area, as now accepted, is borne out by post-mortem examination.

#### THE PLASMODIA OF MALARIA.

DR. J. S. THACHER exhibited fresh specimens and stained ones of the plasmodia, which had been found in great abundance in the blood of a patient in the Presbyterian Hospital in the service of Dr. Northrup.

The patient was a steward on the steamers running between New York and New Mexico, and he had first had chills about two years ago. They ceased to recur after three or four months, and did not trouble him again until early last November, just after a return voyage to New York. Between this time and that of his admission to the hospital on January 24th, he had frequently chills at irregular intervals. During his stay in the hospital, he has had two or three irregular rises of temperature, at one time to 104° F., but there was no chill with these elevations of temperature. He was given occasional doses of phenacetin during the first week, and after that he received ten grains of quinine three times a day. Since he has been taking the quinine, there has been no rise of temperature, but the parasites have been continuously present in his blood, although in steadily decreasing numbers. The crescentic forms have been almost exclusively present, although there have been some of the round, pigmented, extra-

cellular plasmodia, and some of the flagellated bodies. The latter were very abundant on the day the quinine was begun, but since then they have been only occasionally present. The intra-cellular plasmodia have not been observed in this case, except possibly on one occasion.

Two methods of preparation have been followed, viz., one was to take a minute drop of fresh blood on a cover-glass, squeezing it on to a slide so as to flatten out the red blood cells, and so enabling the observer to more easily see the plasmodia. The other method was to obtain a very thin and quick "smear" by touching the edge of a slide to a drop of fresh blood, and then wiping it quickly across a cover-glass, then passing it through the flame just as is done in staining sputum, after which it was stained with methylene blue.

The number and character of the plasmodia have not varied much with the time at which the examination was made, although Laveran found them almost constantly present if the blood were examined just at the beginning of a paroxysm, occasionally absent if the examination were made towards the end of the paroxysm, and quite often absent when the examination was made during the interval. Although this patient has not had any elevation of temperature for over a week, there is still a number of crescents found in his blood. The speaker thought that most cases diagnosed as malaria, and running a fairly typical course, would show the presence of the plasmodia, but of course there are many cases called malaria by some physicians which do not show them.

Dr. Le Boutillier asked if the plasmodia had been observed outside of the body?

Dr. Thacher replied that they had been extensively studied in the lower animals, and that quite similar growths had been found as parasites of plants.

Dr. J. M. Byron said that the well known clinician, Professor Bacelli, of Rome, a very excellent authority on malaria, states that he has been unable to find the plasmodium in cases which he had diagnosed as malaria, and which proved afterwards to be typical cases of the chronic form of this disease.

DR. HENRY S. STEARNS then gave a lantern exhibition, in which he showed many interesting photo-micrographs of various pathological conditions.



*Stated Meeting, February 22, 1893.*

DR. H. P. LOOMIS, PRESIDENT.

APPENDICITIS.

DR. W. P. NORTHRUP reported a case of appendicitis with some unusual clinical features, and exhibited the appendix and specimen under the microscope. The patient was a man, thirty-two years of age, who was very ill last summer for a period of six weeks with what the physician in attendance at that time supposed to be an attack of peritonitis. When the speaker first saw him, in the fall, he was extremely pale and emaciated, and looked to be a subject of tuberculosis. On the morning of January 24, 1893, the patient had two natural stools, and about noon began to have cramps all over the lower part of the abdomen. He was seen by the speaker at 6 P.M., just after he had had a chill and had vomited. The axillary temperature was  $101^{\circ}$  F., and there was some tenderness low down in the right groin. The diagnosis was made of appendicitis. At 4 A.M. on January 25th, he was reported to have had another severe chill, and two hours later he vomited some greenish water, and the axillary temperature was  $103.5^{\circ}$  F. There was another slight chill at 1 P.M., followed by a temperature of  $104^{\circ}$  F. The patient was slightly delirious, and had the appearance of one suffering from septic poisoning. After consultation with Dr. Lange, who agreed in the diagnosis that an abscess had formed, and was on the point of rupture, or that possibly even some leakage had already occurred, an operation was immediately undertaken. The appendix and a portion of the cæcum were found of a dark purplish color, and there was beginning gangrene of the mucous surface, so that after ligating and removing the appendix, the wall of the cæcum was invaginated and the two peritoneal surfaces sutured together, so that in case of sloughing of the wall of the cæcum, the slough might escape into the bowel. On section, the appendix was found to be empty, its mucous membrane was the seat of gangrene, and the solitary follicles were ulcerated. These changes were not at all extensive, and were confined to the cæcal extremity of the appendix. Since the operation, convalescence had been uninterrupted.

A DISSECTING ANEURISM OF THE ASCENDING PORTION OF THE  
ARCH OF THE AORTA.

DR. F. FERGUSON presented a specimen of a dissecting aneurism of the ascending portion of the arch of the aorta which had been taken from a man, thirty-six years of age, who had been apparently in perfect health up to two days before death, when he suddenly felt ill while on his way to business. On admission to the hospital, he complained only of feeling greatly prostrated, and no physical signs were observed pointing to any pathological condition of the heart or lungs, and the heart action was slow and vigorous. His urine contained a trace of albumen. He passed a restless night, but early the following morning felt somewhat better. At 11.45 A.M., he suddenly fell dead. At the autopsy, the lungs were found to be fully aerated, and the kidneys showed chronic congestion. There was a rent in the aorta, 3 cm. in length, the lower end of which was about 1 cm. above the aortic valve. It involved the intima and the middle coat of the vessels, and from this point the artery was dissected towards the heart and downward as far as the bifurcation of the iliac arteries. In addition to this, there was a rupture into the pericardium about one fourth of an inch in diameter, almost at the junction of the vessel with the heart. Through this, about six ounces of blood had escaped into the pericardial cavity and found coagulated at the autopsy.

The case was of unusual interest, both on account of the vessel showing no evidence of degeneration, and also because of the great size of the rent.

## THE LESIONS OF TYPHUS FEVER.

DR. WILLIAM G. LE BOUTILLIER presented a spleen which had been removed from a typhus fever suspect. The patient had an eruption and all the symptoms of typhus fever, and at first there was no evidence of pneumonia. On the following day, however, the physical signs indicated consolidation of the entire lung on one side, and at the post-mortem examination, held four days later, it was found that this lung was in the stage of gray hepatization. With the exception of some decolorized clots of fibrin in the heart, the blood was very dark and tarry. The spleen was large and quite soft. The lower portion of the intestine was very much injected, and showed distinctly the "shaven beard" appearance.

The case was presented chiefly with the idea of ascertaining the opinion of the members as to whether or not this really was a case of typhus fever.

Dr. J. W. Brannan said that last spring he had made four autopsies on undoubted cases of typhus fever. In these cases, the intestine showed no lesions whatever, the lungs showed hypostatic congestion, and the spleen was very large and soft, but the appearances were altogether negative. Acute degeneration of the liver and kidneys was the most marked feature in all the cases.

Dr. J. M. Byron said that in 1881 he saw about 7000 cases of typhus, and made autopsies on about 350 of these cases, and although, in all these examinations, a special search was made for anything which might be considered characteristic of the disease, no such post-mortem evidence was obtainable. Sometimes the intestine showed the rosy appearance already mentioned. The spleen was enlarged as it is also in all infectious diseases, and in a large proportion of cases there was some croupous pneumonia, usually in the lower lobes, but in almost all depressing diseases, if they be sufficiently protracted, this condition will be found. The blood was usually dark and fluid, but no more so than is often observed in other infectious diseases.

Dr. George P. Biggs said that his post-mortem observations of typhus fever cases accorded with those of the last speaker, except that he had not found pneumonia especially common. There was nothing unusual about the appearance of the intestine, the spleen was invariably large, there was usually acute parenchymatous degeneration of the heart, liver, and kidneys, particularly of the latter. The blood was very dark and fluid. From the appearance of the spleen which had been presented, he would be inclined to think that, in addition to the lobar pneumonia, there must have been some infectious process, so that the post-mortem findings, when taken in connection with the clinical history, pointed strongly to typhus fever.

#### RENAL CALCULI.

DR. LE BOUTILLIER also presented a kidney showing three calculi in its pelvis. The largest was branched and of irregular shape, and measured about 10 x 18 x 30 mm., and weighed 4.5 grm. There were two small calculi weighing together .6 grm. They were situated in the most dependent portion of the pelvis

of the kidney, and, with the exception of the facets, they had a smooth surface. The ureter was normal, as was also the bladder, which contained no calculus. The calculi in the kidney were of a dark brown color, and appeared to consist of uric acid. The kidney itself showed cloudy swelling from the intercurrent disease which caused death, but there were no suppurative changes.

#### CHRONIC INTERSTITIAL PNEUMONIA.

DR. J. W. BRANNAN exhibited the lungs from a man, sixty years of age, who about one year ago had been discharged from Bellevue Hospital with a diagnosis of "fetid bronchitis," and had been re-admitted, within the past few weeks, with very much the same symptoms as he presented on the previous occasion. This time, on admission, his temperature was 103° F., and the physical signs pointed to an empyema on the right side. The expectoration was fetid, but no bacteriological examination was made of the sputum. On February 6th, portions of two ribs were exsected, and a large quantity of offensive pus evacuated. The temperature fell, and remained down for two days, but then rose, notwithstanding the existence of free drainage, and a diminution in the fetor. He finally died of exhaustion, and the autopsy was made to-day. The right pleural cavity was obliterated, and the right lung, instead of being tubercular, as had been surmised, presented the appearance of one which was the seat of a chronic interstitial pneumonia. With the exception of some emphysema and congestion, the left lung was normal. There was no evidence of tuberculosis elsewhere.

The right supra-renal capsule was also exhibited, and appeared to be in a state of fatty degeneration. The specimen was referred to the Committee on Microscopy for examination.

#### A CASE OF PYÆMIA FOLLOWING THE INCISION OF AN URETHRAL STRICTURE—WITH A NOTE OF CERTAIN BIOLOGICAL PECULIARITIES IN THE STAPHYLOCOCCUS PYOGENES AUREUS.

By T. MITCHELL PRUDDEN.

I am indebted for the story and the specimens in this case to my colleague, Dr. Eugene Hodenpyl.

A man of twenty-four, of whom nothing could be learned except that the day before he had been cut to 30 for an urethral

stricture, and that the next morning his temperature was 106.6° F. and he became delirious, was admitted to the hospital, pulse 130, respiration 36, urine acid, sp. gr. 1013, with 60 % of albumen, pus and granular casts.

The delirium continued, the pulse grew feeble, the temperature rose to 108.4° F., and on the second day after admission he died. The heart and lungs were normal; the spleen soft; both kidneys were normal in size and with free capsules, and were studded with small petechial spots and abscesses. The peritoneum and the mucous membrane of the bladder were in places the seat of numerous petechiæ.

The microscopical examination of the kidneys showed tiny abscesses containing cocci and numerous bacterial emboli in the smaller vessels. The spleen sections showed numerous cocci. Cultures from the kidneys and spleen gave similar results, namely, they revealed the presence in large numbers of cocci, which ultimately proved to be *staphylococcus pyogenes aureus*. No other bacteria were found in the cultures. Intravenous injection of beef-tea cultures of the cocci in the rabbit caused the death of the animals, about the fifth day, with multiple abscesses of the kidneys.

A noteworthy peculiarity in the growth of these well known pyogenic germs isolated from this case, and one which was at first very puzzling, was the extreme slowness with which they fluidified gelatin and coagulated milk. Although various preparations of nutrient gelatin were tried, all of which with cultures from other sources comported themselves in the usual way, and although the conditions were largely varied, with this culture ten days would as a rule elapse before fluidification became evident, and often at the end of a month it had advanced but slightly in the lateral or along the puncture line. The coagulation of milk at 37° C. was not evident until the fifth or sixth day. The growth of this germ was abundant, and the color moderately bright, but its metabolic powers in the way of the production of the usual peptonizing material, and its milk-coagulating capacity were at a low ebb. These peculiarities it retained after having passed through rabbits, and cultivated again from their renal abscesses. Variations of this sort in the metabolism of the various species of bacteria are not uncommon, but in this case the variation was so marked as at first to fairly mask the characteristics upon which we usually depend for identification. During the observations

which were made on this particular variant of the staphylococcus, generation after generation was developed, and in the course of six months, with how many transplantations I do not know, the germ slowly recovered its metabolic powers, until now it possesses a capacity for fluidifying gelatin and coagulating milk which departs in no noteworthy way from the usual samples which one cultivates from suppurative foci. Its effects on rabbits after intravenous injection are about the same as before, rapidly inducing abscesses in the kidneys on intravenous injection. It has therefore recovered its normal powers under prolonged artificial cultivation.

I report these observations in this case *first*, because they illustrate the hazards which may belong to so common an operation as the cutting of an urethral stricture, and, *second*, because they illustrate that variation in bacterial metabolism which, when we know its limitations better, may be more significant than it now seems in accounting for certain variations in the phenomena of infectious diseases.

Dr. Byron said that these observations concerning the metabolic characters of the staphylococci were exceedingly important as showing that such characteristics were not sufficient ground in themselves for the division of bacteria into species.

#### A CYST OF THE BRAIN.

DR. J. H. HUDDLESTON presented a brain showing a cyst occupying the ascending parietal convolution. The specimen had been removed from a patient who had died very suddenly at the almshouse. The left side of his body had been paralyzed for some years.

The heart from the same patient showed a parietal thrombus occupying the left auricle. It was 5 ctm. in diameter, globular in shape, and its base of attachment was about the size of a half dollar.

#### SOLITARY TUBERCLE OF THE LIVER.

DR. GEORGE P. BIGGS presented a liver which had been removed from a woman seventy years of age, a patient in the almshouse. No detailed history could be obtained, but it was learned that she had had attacks of jaundice at intervals for several years, the last one being accompanied by high fever. The liver showed

a nodule about the size of a hen's egg, projecting from the upper border of the liver, and slightly adherent to the diaphragm. It was distinctly outlined by a layer of dense fibrous tissue, and in the recent state it presented an appearance very much like that of a gumma. The liver also showed moderate fatty and fibrous change, with marked dilatation of the gall-ducts; the gall-bladder contained many gall-stones, and there was suppuration in and about the gall-bladder. The lungs showed a few tubercular nodules at each apex, and also in the upper portion of the middle lobe, and there was a small spot of pneumonia, beginning to suppurate, in the middle lobe of the right lung. The kidneys were the seat of advanced chronic diffuse nephritis. The liver in the fresh state was examined for bacilli, but none was found; yet sections of the tumor, when examined under the microscope, showed typical tubercular tissue. It was quite a typical specimen of what some writers have called "solitary tubercle" of the liver.

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*Stated Meeting, March 8, 1893.*

DR. R. H. SAYRE, VICE-PRESIDENT.

PURULENT MENINGITIS.

DR. WARREN COLEMAN presented specimens from a case of purulent meningitis, which was of special interest on account of the peculiar distribution of the pus, and the absence of any satisfactory explanation of its origin. No proper history was obtainable, but it was learned that the patient, who was thirty-five years of age, had been suffering from malaise, and had had a temperature of 102.5° F. for a short time previous to his admission to the hospital. Shortly after admission he became comatose, and remained in this condition until his death, twenty-four hours later. At the autopsy, the pus was found under the pia all over the convexity, and somewhat over the vermiform process, but the base was remarkably free from it. There was a purulent liquid in the spinal canal. At first it was thought that the condition was of tubercular origin, but no bacilli were found in the pus. The heart from the same patient was found hypertrophied, its vessels injected, the wall thickened, and the cavity dilated. One chorda tendinea was situated across the ventricle near the

apex, and another near the base, the latter being in such a position that it must have given rise to a murmur during life. Both cavities were filled with clots which had formed some hours before death. The left cusp of the aortic valve was the seat of a recent vegetation; the other two were thickened in places. The mitral valve was retracted and slightly thickened along its free border. The lungs did not collapse on opening the thoracic cavity. There were a few slight adhesions at the left apex, and the upper lobe of this lung was contracted from pleurisy. On section, this lobe was found studded with miliary tubercles, and there was one small cheesy mass at the apex. The lower lobe showed only congestion and œdema. The right lung was in about the same condition. The intestines looked normal, and were not opened. The spleen and pancreas were normal. The liver showed cirrhosis, congestion, and some fatty change. The kidneys were the seat of chronic diffuse nephritis.

Dr. E. D. Fisher said that he did not remember to have seen such an extensive purulent meningitis without more involvement of the base, and the symptoms were not at all sufficient to account for the compression which must have been produced. Although considerable time must have elapsed between the commencement of the inflammation and death, the condition could hardly have been diagnosticated during life.

Dr. Coleman said that the house physician had been led to infer from the symptoms that there had been an injury to the skull, but, being unable to localize it, an autopsy was requested.

#### THE RESULTS OF INSTRUMENTAL ABORTION.

Dr. A. T. Weston exhibited the uterus and appendages from a woman who died twenty-eight days after an instrumental abortion. There was a sloughy area in the uterus undoubtedly indicating the use of instruments. The left Fallopian tube was enlarged, and filled with pus, and between it and the pelvic wall posteriorly was an abscess cavity containing about two ounces of fluid pus. The only history obtainable was that an abortion had been produced, and that the patient had had an attack of peritonitis from which she seemed to have almost recovered, when there was a sudden relapse and a fatal termination. At the autopsy, the peritoneum was found to be normal, with the exception of a few small points of recent adhesion which were found in connection



with the condition just described. Death was undoubtedly due to exhaustion incident to the pelvic abscess.

The speaker also read notes of five other recent cases of this kind. The marks of instruments were plainly seen in one; they were not visible in two; in two there was considerable doubt as to whether certain small ulcerated areas were due to instruments. In three of the cases, death occurred about ten days after the abortion, and was due to septic peritonitis, and in two, death occurred twenty days or more afterwards, and was due to septi-cæmia.

#### PERFORATION OF THE LUNG.

DR. E. HODENPYL presented two specimens of perforation of the lung in which death almost immediately followed the perforation. The first patient was thirty-five years of age, and his last illness began three months before his admission to the hospital on January 21, 1893. Previous to admission there were cough, mucopurulent expectoration, dyspnœa, and progressive loss of flesh and strength. Four weeks before coming to the hospital, after exposure to cold, the patient became hoarse. At the time of admission there was marked prostration; pulse 112, respirations 28, temperature 103.6° F. Over the left chest in front the breathing was much diminished, and in the first space it was amphoric. Over the left side, posteriorly, there was dulness to a point midway between the spine and angle of the scapula; breathing and whisper were amphoric. Over the right chest, in front, there was dulness in the first and second spaces with greatly diminished breathing, and below this, the resonance was tympanic, the breathing was harsh, and there were numerous friction sounds. Posteriorly, there was dulness to a little above the angle of the scapula. Near the spine there was an area of cavernous breathing. From February 10th to 26th there was moderate diarrhœa. On the morning of February 27th the patient suddenly died. At the autopsy, on opening the right side of the chest, gas escaped. The pleural cavity contained a sacculated accumulation of greenish fluid with considerable fibrin. About the middle of the upper lobe was a circular perforation of the pulmonary pleura about one eighth of an inch in diameter. The upper lobe was consolidated and fibrous, and contained a large, irregular cavity, and many miliary tubercles. The lower lobe contained a few tubercles. The entire left lung was consolidated

and studded with tubercular nodules, and there were cavities in the upper lobe. The appendix vermiformis was the seat of tubercular ulceration, and both the large and small intestine were studded with tubercular ulcers of various sizes, some of which involved the serous coat of the intestine. The larynx and trachea were extensively involved in the tubercular process. With the exception of some fatty degeneration of the heart and liver, the other organs were normal.

In this case, there were practically no throat symptoms, notwithstanding that the epiglottis was entirely ulcerated away. The diarrhœa was also very moderate, considering the very extensive involvement of the bowel.

The second patient was said to have been ill for about one year, and to have been confined to bed for the greater part of the last two months of her life, yet just before the perforation occurred, she was busy sweeping. While thus engaged, she was very suddenly seized with an agonizing pain in the chest, and although quickly removed to the hospital, she died within a few minutes after admission.

Dr. J. W. Brannan cited a case of pneumothorax which had not been diagnosticated, but in which there was every reason to believe the patient lived five or six days after its occurrence. The case was one which had been in the hospital for three or four weeks with symptoms which had led to the diagnosis of typhoid fever, and when he first saw the patient, it was supposed to be in the fourth or fifth week. Four or five days before death he was found one morning quite cyanotic, and this condition continued up to the time of his death. The autopsy showed the left pleural cavity filled with air, and the lung retracted and compressed in its upper portion. The lung contained two rather large cavities, both of which communicated freely with the pleural cavity. There were tubercles and cheesy degeneration in the right lung, but no cavities. There was absolutely no involvement of Peyer's patches, so that the diagnosis should have been acute tuberculosis instead of typhoid fever. In this connection it was interesting to note that the house physician had remarked that this was the first case of typhoid fever which he had known to protest vigorously against the use of the cold bath, or in whom reaction had not been readily established after the bath.

Regarding the effect of perforation of the lung on the system, Fagge says that if the pneumothorax occur into the relatively

sound lung, its occurrence is apt to be marked by severe symptoms, and death speedily follows; but that if the pneumothorax occur on the side which is the more extensively diseased, that is to say, in the lung which is not much used, the symptoms may not be urgent, and death does not occur for some time afterward, or the patient may even recover. In the case which he had just reported, the pneumothorax occurred on the side of the chest which was the more diseased.

Dr. George P. Biggs thought that in many cases pneumothorax did not cause sudden death. He could recall a case of pyopneumothorax with abundant purulent effusion, in which the lungs were not very extensively involved, where, after drawing off the pus, the patient was discharged from the hospital in good condition.

Dr. J. H. Huddleston said he had seen two cases of pyopneumothorax in hospital, both of which recovered, and were known to have been alive for a long time afterward.

Dr. W. P. Northrup referred to a case in his service at the Presbyterian Hospital in which the history showed that the pyopneumothorax in all probability dated back two months. The case had been seen in consultation with Dr. Janeway, who thought that if aspiration were performed, there was a fair prospect of recovery.

Dr. W. G. Le Boutillier said that in Dr. Hodenpyl's cases death was probably due to shock, whereas in many other instances in which the fatal termination is not so sudden, death apparently results from compression and obstruction of the circulation.

DR. W. G. LE BOUTILLIER presented specimens of

ANEURISM OF THE MITRAL VALVE—CEREBRAL EMBOLISM.

J. M., fifty-four, Ireland, married, a laborer, was committed to the workhouse September 24, 1892, and was placed at indoor work as he seemed a little stupid. He was apparently well March 2, 1893, and worked as usual up to dinner time. A few moments after dinner, while sitting on his cot in his cell, he was seen to fall over to the left onto the cot. He appeared to try to raise himself up, was unable to speak, and the House Physician was summoned, being told a man was having a fit. The House Physician saw the man not more than ten minutes after the

beginning of his attack, and found him lying on his left side, moving the left leg and arm as if in an attempt to raise himself. The right side was not moved at all, and arm and leg were rigid. He did not appear to understand questions and did not speak. Respiration was stertorous, face dry and congested, temporal arteries full. Inquiry from the other occupants of the cell gave no further information in regard to his illness.

3.45 P.M.—Patient lies on back, in an unconscious condition. Respiration labored and rapid (60 to the minute), and noisy from accumulation of liquids in pharynx. The face is flushed and moist, conjunctivæ congested, eyes turned to left with vertical and horizontal oscillations. Pupils, equal in size, seem to be contracted moderately, react to light. Both eyelids closed, cheeks not puffed out with expiration, temporal arteries very full and pulsate visibly. Radial pulse, full, hard, 104. Temperature in rectum  $101\frac{1}{4}^{\circ}$  F. Surface, except face, dry. Patient seems very restless, constantly moving left arm and leg, while the right side remains motionless. The right arm, slightly flexed at elbow, is held otherwise rigidly extended and pronated so that ulnar border of hand is directed upward. Right leg extended, and rigid with fibrillary twitches of muscles of leg and thigh. Urine voided in bed, although it was drawn with catheter a short time previously; contains albumen. Reflexes could not be determined. Noisy breathing prevents any result of physical examination of chest.

At 2 P.M. had been given croton oil; now ordered an enema, and bowels moved freely. At 6 P.M. vomited large quantity of undigested food. Remained comatose and could not be aroused but seemed at times to have slight consciousness. Coma, if possible deepened, and at 2 P.M., March 3d, pulse irregular in force and rhythm, 60 to 80; temperature,  $104^{\circ}$  F.; respiration, Cheyne-Stokes. Eyes no longer turn to left, pupils immobile, unequal, left seeming of normal size and right contracted. Has vomited a quantity of thick greenish material. Muscular fibrillary twitches of right thigh and leg continue. Right arm appears completely paralyzed, and leg is less rigid. Has not moved right side since attack began. Left side quiet, not paralyzed. Patellar tendon reflex on right side exaggerated, on left side normal. Condition continued about the same with temperature rising to  $107^{\circ}$  in the rectum; and sweating of entire body until death at 5.30 A.M., March 4th, forty-two hours after beginning of attack.

AUTOPSY—Nine hours later.

Body, well nourished, rigor mortis present, no œdema; peritoneum, pericardium, pleuræ, normal, except for a few old adhesions at both apices.

Lungs under adhesions show some fibrous thickening, and at right apex a dark, reddish-black area, 3 cm., by 5 cm., and 1.5 cm., thick, firm, non-crepitating, suggesting an infarction. Elsewhere lungs moderately emphysematous, no œdemia, bronchi, congested.

Heart, increased in size, weighs 19½ ounces. Left ventricle hypertrophied, 23 mm. thick. On auricular surface of anterior segment of mitral valve two small projections that were at first supposed to be "vegetations." They proved to be too small aneurisms about 3 mm. in diameter, opening on the ventricular surface by very small orifices, containing no clots, and without any sign of ulceration. Elsewhere the mitral valve had one or two very small areas of slight thickening. Aortic valves and those of right heart normal. The coronary arteries and aorta had undergone extensive atheromatous change with areas here and there of calcification.

Spleen normal. Kidneys, small, capsule not adherent, surface smooth, cortex thin, markings obscure.

Liver, soft from fatty change.

Brain, calvarium, dura, and sinuses, normal. Pia seems very dry over whole convexity, and blood-vessels are much injected, especially on left side. Vessels at base thickened and atheromatous. Whole left hemisphere seems very soft. On inferior surface of left frontal lobe, at inner portion, is an area 4 cm. long, 3 cm. wide, the seat of numerous punctate hemorrhages. Ventricles contain no excess of fluid, and no blood; the ependyma of right is granular. In floor of left lateral ventricle in corpus striatum is another group of punctate hemorrhages. With the exception of the extreme front and inner portion of frontal lobe, and the posterior and inner portion of occipital lobe, the whole of the left hemisphere was very soft and readily disintegrated, almost liquefying under manipulation and apparently being held together externally by the pia mater. Color was normal.

The cerebral vessels had areas of atheromatous change scattered through them irregularly on both sides. On the left side, the middle and anterior cerebral arteries each contain clots adherent to the intima, apparently due to embolism.

## STRICTURES OF THE VERMIFORM APPENDIX.

DR. GEORGE P. BIGGS presented two specimens of stricture of the vermiform appendix. The first one was removed from a patient dying of chronic alcoholism, and without any history, so far as known, of symptoms referable to the condition of the appendix. The appendix lay entirely behind the cæcum, and was 9 cm. long, and 2 cm. in diameter. It had a distinct mesentery except at its tip. About  $\frac{1}{2}$  cm. from its origin its lumen was occluded by firm fibrous bands, which had evidently formed at some previous time in the course of a reparative process following a localized sloughing. The contents of the appendix measured 2 drachms, was of a slightly pinkish color, and consisted of fat globules, granular matter, and cholesterine crystals.

In the second case, the vermiform appendix lay between the two folds of peritoneum forming the mesentery of the lower portion of the ileum, instead of having a free mesentery of its own. In this case, the tube was about 8 cm. in length, and  $\frac{3}{4}$  cm. in diameter. There were two distinct points of obstruction near the tip which were apparently not the result of disease, but due to sharp curvature of the tube produced by the tight peritoneal investment. The patient died of advanced Bright's disease.

Dr. Hodenpyl said that this interesting condition was a comparatively common one—he had observed it no less than three times within the past week—and it explained the origin of many cases of appendicitis. A few years ago, Dr. McBurney stated that if the appendix were diseased, firm pressure just over the appendix would always elicit pain; but Dr. Weir subsequently found that he was able to elicit pain by making pressure at this point in a number of supposedly healthy persons. Possibly these two statements might be reconciled by the existence of some such lesion as that exhibited in these specimens.

Dr. George P. Biggs said that he had made a number of experiments for Dr. Bryant relative to the location of the appendix, and its base was frequently found a considerable distance above or below "McBurney's point," so that tenderness at this point was after all a very disappointing sign. In making these experiments, long needles were passed down through the abdominal walls before opening the abdomen.

Dr. S. T. Armstrong said that recently he saw a patient who was chilly and feverish, and decidedly tender at this point. It was thought at first that an operation would be required, but by

the next day all these symptoms had disappeared, and the case proved to be simple malarial fever.

Dr. Huddleston had seen twenty-two bodies examined in a dissecting-room with reference to the relation of the vermiform appendix to this point, and in only one of these did the needle pass through the abdominal wall within one inch of the base of the appendix.

Dr. T. H. Manley thought one of the specimens presented looked as if the occlusion were of congenital origin. In a recent post-mortem examination he had found the appendix lying behind the cæcum.

#### A MALIGNANT TUMOR OF THE TONSIL.

DR. ROBERT C. MYLES exhibited a portion of a tonsil which he had removed from a woman seventy years of age. There was an enormous malignant growth, probably a sarcoma, in the throat, connected with it, and the patient was unable to swallow. In removing such large growths, the great danger is from hemorrhage, but in this case, the removal was rapidly and successfully effected by using a No. 18 platinum wire with a powerful galvano-cautery battery. It is necessary for this particular work that there should be an abundance of current at the disposal of the operator.

#### OMENTAL HERNIA.

DR. T. H. MANLEY exhibited three specimens of omental hernia which he had removed by operation, and also one of hernia of the ovary, occurring in a little girl about two months old.

#### VERY EXTENSIVE DYSENTERIC ULCERATION ASSOCIATED WITH MILD SYMPTOMS.

DR. HUDDLESTON presented specimens taken from a woman, fifty-one years of age who had suffered first from diarrhœa, and then from an intractable form of dysentery. She had ten or twelve bloody stools a day, but no pain; the abdomen was somewhat shrunken but not specially sensitive, and the physical examination was practically negative. Opiates, astringents, and irrigations had no effect on the disease. She gradually wasted away, and died of exhaustion. The post-mortem examination showed the lesions to be chiefly confined to the colon, which was the seat of such very extensive ulceration, that the slight move-

ment of turning back the mesentery was sufficient to tear the colon from one end to the other. Throughout the entire colon there were only small areas which had escaped the ulcerative process, and in several places the ulceration had extended through the muscular layer down to the peritoneum. The kidneys showed some slight cirrhotic changes, and situated upon the left kidney, though not entering into its structure, was a cyst about 6 inches in diameter, which was filled with clear yellow fluid. The cyst wall showed numerous areas of calcification.

Dr. Northrup said that he had seen an exactly similar case of ulceration occurring in a student, who gave a previous history of chronic constipation. He suffered from a low type of fever, and the clinical symptoms gave no indication whatever of the nature and extent of the lesions.

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*Stated Meeting, March 22, 1893.*

DR. H. P. LOOMIS, PRESIDENT.

A LIPOMA IN THE INGUINAL REGION.

DR. WARREN COLEMAN presented a lipoma which is of interest because of its situation. It comes from a man about sixty years old. He was an almshouse patient, and I could obtain no history. Upon inspecting the body, I found a swelling in the left inguinal region about the size of a hen's egg, which I supposed to be a hernia. I carefully dissected through the skin and subcutaneous tissue, and was surprised at not finding a sac. The mass consisted of two lobes, deeply red, resembling knuckles of intestine, and seemed to pass up through the inguinal canal. I then opened up the abdominal cavity. The intestine was lying perfectly free, though over the internal ring. The omentum was of normal length, with its free border perfectly intact. I was more than ever surprised. On passing my finger up through the external ring I could feel an isthmus connecting the two lobes. Beyond this the internal ring was found closed over by peritoneum.

The tumor lay a little internal to the spermatic cord and its vessels; though there was some compression of the latter, as shown in the tortuous condition of the spermatic veins, there was no varicocele.



The tumor was deeply congested and has a hard feel. There is a distinct but thin fibrous capsule surrounding it, which easily strips off. I don't think it can be peritoneum, for it closely invests both lobes and the isthmus. Running down into the inner lobe is a sort of canal, but I could not establish any connection between it and the abdominal cavity. On cutting into the tumor, small fibrous trabeculæ are found traversing it, and the surface presents a bright glistening aspect. Its real nature, however, is obscured by the large amount of blood it contains. In the section under the microscope you will see that it is made up wholly of fat cells held together by bands, for the most part small, of fibrous tissue. The fat cells are large, and running in amongst them are numerous blood-vessels. In some instances the cells are entirely surrounded by large dilated capillaries full of blood.

Inguinal epiploceles are most frequent in old people, and on the left side. When of long standing, they may have their structure entirely changed. Macfarlane, in the *Medico-Chirurg. Trans.* of London, speaks of a case he had seen where the portion of omentum contained in the sac "had lost every vestige of its natural structure, and had become exceedingly bulky, indurated, and tuberoso." But the fact that there was no sac surrounding the tumor—I don't believe that the fibrous capsule surrounding the two lobes individually can be the remains of a sac—and that the free border of the tumor was intact makes me look for some other source of origin.

Externally the tumor might be confounded with a partial enlargement of the spermatic cord, but the dissection showed the cord to be of normal size and entirely distinct from the growth.

On consulting the literature I find that fatty tumors are sometimes developed external to the inguinal ring, and also that they may form in the cellular tissue below the peritoneum in the neighborhood of the internal ring and be extended. These tumors and the changed, irreducible epiploceles present nearly the same appearance.

I am inclined that the tumor before you was developed independently of the omentum.

#### ADHESIVE PERICARDITIS.

DR. J. H. HUDDLESTON presented a specimen of adhesive pericarditis which had been removed from a woman dying of pneu-

monia. The pericardium was very extensively adherent over the back of the heart; there were no adhesions about the lungs.

DR. HUDDLESTON also presented several other specimens removed from a woman fifty-five years of age, who died presumably of pneumonia. The post-mortem examination showed two small areas of pneumonia surrounding an infarction. A clinical diagnosis had been made of fracture of the neck of the femur, and at the time of death the patient was wearing a spica bandage. At the autopsy it was evident that there was limitation of all the motions about this joint, and some of those present thought they felt a slight crepitus. On excising the head of the bone and making a section through it, it was found that there was no fracture, but that there were osteophytes, and a state of chronic arthritis and osteitis which may have given rise to the crepitus. The uterus from the same patient was found enlarged to the size of a large orange, and the left Fallopian tube was moderately dilated. On opening the uterus, there was a gush of odorless pus, and it was found that the whole uterine cavity had been converted into an abscess cavity. An *ordinary* microscopical examination showed nothing peculiar about this pus. On the intestine, mesentery, and omentum were a number of small, white, elevated spots, of which no microscopical examination had yet been made. The lungs presented no evidence of tubercle; the bronchial and abdominal lymph nodes were not notably enlarged, and no evidence of tuberculosis had been found, unless the uterus and tubes were proved to be tuberculous.

Dr. George P. Biggs said that all the specimens of tuberculosis uteri which he had seen had shown a distinct cheesy layer and a thickening of the wall instead of a thinning as in this specimen. The nodules in the mesentery resembled tubercles.

The specimen was referred to the Committee on Microscopy for examination and report.

#### EPIDEMIC CEREBRO-SPINAL MENINGITIS.

DR. GEORGE P. BIGGS presented a brain and spinal cord removed from a negro laborer, twenty years of age, who had been in perfect health up to March 18th, at which time he had a chill, followed by headache and delirium. On the 20th he was admitted to the New York Hospital in an unconscious condition, with

marked rigidity of the head, neck, and back, but there was no paralysis and no convulsions. On the following day he roused sufficiently to answer a few questions, and then again relapsed into coma. His pulse was rapid and feeble throughout, and the temperature did not go above 101° F. At the autopsy, a purulent exudation was found over the base of the brain, especially between the lobes of the cerebellum, and along the course of the vessels over the entire convexity. On removing the spinal cord, no exudation was found until a point just below the cervical enlargement of the cord was reached, when a purulent exudation was discovered, and found to extend downward over the whole posterior surface of the cord.

Dr. Biggs also reported in this connection another case of the same disease which developed in another negro of about the same age, who lived in the same house with the other patient, and was his companion. He was taken sick on March 17th, but there was no distinct chill, and no noticeable rigidity of the back and neck. The pulse was rather rapid and feeble, the temperature about 101°, and he appeared simply stupid. He died rather suddenly before a diagnosis had been made. At the autopsy, the lateral ventricles of the brain were found to contain turbid serum, and the entire surface of the brain showed acute purulent leptomeningitis. The pia of the cervical region was free from exudation in this case also. The ileum from this patient was also exhibited to show an unusually deep pigmentation of Peyer's patches. The pia of the medulla showed the pigmentation found most commonly in colored people. Cultures from this patient's brain at the end of twenty-four hours showed apparently a pure culture of a comparatively large bacillus, but its nature has not yet been determined.

Dr. J. M. Byron said that in view of the fact that while most cases of epidemic cerebro-spinal meningitis are believed to be due to the pneumococcus of Fraenkel, a few cases had been attributed to the presence of Wechselbaum's bacillus, it would be specially interesting and important to subject the specimens just presented to a very careful microscopical examination.

STRICTURE OF THE RECTUM ; PERFORATION PRODUCED  
BY DILATATION.

DR. GEORGE P. BIGGS then exhibited a specimen of extensive stricture of the rectum occurring in a woman forty years of age.

The first symptoms apparently dated back about nine months, at which time an obstruction was first noticed. No specific history could be obtained. From time to time she had been temporarily improved by dilatation of the stricture by soft bougies, but after the last dilatation, about four days before her death, she complained of so much pain that she was brought back to Bellevue Hospital. Examination showed beginning peritonitis, which ran a rapid course. At the autopsy, the lower four inches of the rectum were found to be very tightly strictured, and the wall of the rectum fibrous and thickened. The mucous membrane over the strictured area was completely destroyed. About one and a half inches above the upper level of the stricture and on the right side of the gut, was an opening about the size of the head of a pin, which was evidently in the base of an old ulcer. Just to the left of this point the mucous membrane showed a short but distinct recent tear. In all probability, therefore, the perforation was due to the point of the bougie catching in the gut at the site of this old ulcer. The stricture was evidently not malignant, and apparently not specific, but its exact nature has not yet been determined.

#### INGUINAL HERNIA ; PERFORATION OF THE JEJUNUM.

DR. GEORGE P. BIGGS also presented a piece of jejunum which had been removed from a man, forty years of age, who had had a reducible inguinal hernia on the right side for a number of years. The hernia had never given him any trouble. In a friendly scuffle the hernia was compressed by the knee of his friend, and he immediately experienced very severe pain in it. An ambulance was called, the hernia easily reduced, and the man taken to Chambers Street Hospital. He rapidly developed an acute general peritonitis, and died after the receipt of the injury thirty hours. At the autopsy, a number of minute points of superficial ulceration were found in the lower part of the jejunum, and one ulceration which was deeper than the rest exhibited a perforation about one fourth of an inch in diameter.

#### A RAPID FILTRATION APPARATUS FOR AGAR-AGAR AND GELATINE.

DR. J. M. BYRON exhibited an apparatus which he had devised for the purpose of facilitating the troublesome process of filtering

agar-agar and gelatine. It consists of two concentric brass cylinders placed the one within the other so as to form between them a steam-jacket. This space communicates with the interior of the inner cylinder only by means of several holes at the upper part. When it is desired to filter agar-agar, a brass tube having a sieve at the bottom to strain out the coarse impurities is screwed into the cover of the inner cylinder, and it is long enough to dip down into the solution to be filtered, which is contained in this inner cylinder. This brass tube is filled with animal charcoal, and the filtered liquid as it escapes from the top of this tube is conducted away into any desired receptacle. The outer cylinder is provided with a safety-valve, and with a funnel and stopcock. Water is poured through the funnel into the outer cylinder and is there heated to boiling, the steam escaping through the open stopcock and funnel. When it is desired to filter the liquid in the inner cylinder, the stopcock is closed, and then the pressure of the steam forces the fluid through the tube containing the filtering material and out by the central tube. If desired, a Pasteur filter may be substituted for the central tube containing the animal charcoal.

#### HEMORRHAGE INTO THE SUPRARENAL CAPSULE.

DR. SMART, present by invitation, exhibited a specimen showing hemorrhages into the left suprarenal capsule. It was taken from a child who died eighteen hours after birth from extensive pulmonary atelectasis. He asked if such a hemorrhage would be likely to give rise to symptoms.

The President said he had seen it in the adult, and, so far as he knew, it did not give rise to any symptoms.

Dr. Thomas S. Southworth said that only two such cases had been brought to the notice of the Society in the past five years—one by Dr. Prudden in 1889, and the other by Dr. Hodenpyl in 1890. Both cases occurred on the right side, and the capsule was ruptured. In neither case was there a history of instrumental delivery.

Dr. George P. Biggs said that he had recently seen a case in which the entire suprarenal capsule was infiltrated with blood, which formed a layer about half a centimetre in thickness. It apparently occurred a short time before death, and had no bearing on his general condition.

## BILIARY ABSCESSSES OF THE LIVER.

THE PRESIDENT presented the liver from a woman forty-six years of age and intensely jaundiced, who was admitted to Bellevue Hospital on March 16th. She was in a semi-stupid condition and no history could be obtained. From friends seen after the patient's death, it was learned that she had had trouble with her liver for the past two years, and during the last six months had been very sick, complaining most of the time of pain over the region of the liver, increased by the least motion; the jaundice had been constant during the six months. The patient died the day after admission to the hospital. Her temperature while under observation ranged about 102° F.

Autopsy sixteen hours after death, rigor mortis present, all the organs were found in a normal condition except the liver and spleen. The latter was very much enlarged (weight 1½ lbs.,) soft, and of a bright red color. No abscesses or structural changes were found in it. Liver weighed 4¾ pounds, greenish-yellow color, surface somewhat uneven. A number of whitish areas, varying in size from a pea to a small olive, were seen just beneath the capsule; when cut into, these areas were seen to be collections of greenish-yellow pus.

The *gall-bladder* was enormously distended with gall-stones, the common duct was not completely occluded, as bile could be forced into the intestines by pressing on the gall-bladder. The common duct, and the hepatic ducts far in the substance of the liver were dilated and filled with small gall-stones or gravel. These walls showed the evidences of a purulent inflammation. The dilated ducts communicated with a number of smaller pus cavities in the substance of the liver as well as with those seen on the surface of the organ.

One hundred and twenty stones were removed from the gall-bladder and the different ducts; they varied in size from one to one and a half inches in diameter, down to those as small as the head of a pin. The stones showed under the microscope cholesterine crystals and bile pigment, blended with an amorphous mass.

Cultures were made from the pus found in one of the small abscesses near the surface of the liver; only one kind of micro-organism was found—a small short bacillus with rounded ends—(similar in form to the typhoid bacillus but shorter).

In plate cultures which were shown, the bacillus grew in

rounded colonies, concentric in appearance, and liquefied the gelatine. It is difficult to say whether this bacillus stood in causal relation to the abscesses. It is possible to conceive of micro-organisms entering the gall-bladder from the intestines, and when the mucous membrane of the gall-bladder and ducts is inflamed and eroded by the action of the gall-stones, finding a fit soil to develop and multiply. The infection of the liver was without question by continuity along the ducts.

Dr. Byron said that this bacillus resembled very closely a bacillus discovered by a certain physician, and found by him to be associated with yellow fever. It can usually be found in all the organs of the body some hours after death. It is now well known that certain irritants when injected under the skin can produce suppuration without the presence of any pyogenic germ; they act like these germs, causing by their irritation of the tissues, the migration of leucocytes. This is the explanation of the formation of what are known as "non-infectious abscesses."

Dr. George P. Biggs said that in a recent case of biliary obstruction at the time of performing an operation for the establishment of an anastomosis between the gall-bladder and the intestine, the surface of the liver was seen to be covered over with numerous white spots similar to those seen in the specimen just presented. At a subsequent operation, these spots were found to have entirely disappeared, and this suggested the idea that these spots were collections of leucocytes in the dilated ducts, and their disappearance was due to the relief of the obstruction. In this case, there was no evidence of any recent abscess formation.

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*Stated Meeting, April 12, 1893.*

DR. H. P. LOOMIS, PRESIDENT.

ROUND-CELL SARCOMA OF THE THIGH.

DR. F. FERGUSON presented a tumor which had been removed from the thigh of a German stone-cutter, thirty-one years of age. His work necessitates frequent pressure on his thighs.

About two years ago he noticed a small, hard lump, which has increased slowly in size.

The material consists of a mass of soft tissue partly fibrous and

partly muscular (voluntary muscular fibre) including a tumor spindle form in shape, 6 cm. in length and 4 in its longest transverse diameter. In the interior it has undergone extensive degeneration and externally it is limited by an ill-defined fibrous capsule.

Sections show extensive areas of small, round cells supported by a fairly regular stroma of fibrous tissue. There are many areas of degeneration, some of which are quite extensive and others microscopic.

The vascular supply is not abundant. Many slides have been stained for tubercle bacilli but none found.

The tumor is regarded as a round-celled sarcoma.

Dr. T. M. Prudden said that notwithstanding the peculiarities presented by the specimen, he considered it one of small, round-cell sarcoma. The lack of blood-vessels might perhaps account for the areas of necrosis present.

THROMBUS OF THE LEFT MIDDLE CEREBRAL ARTERY AND ITS  
BRANCHES; CEREBRAL SOFTENING ACCOMPANIED BY RIGHT  
HEMIPLEGIA SIMULATING CEREBRAL APOPLEXY.

DR. FERGUSON also presented a brain taken from a male forty-eight years of age and a native of Italy.

When seen at his residence in Mulberry Street he had complete hemiplegia of right side and unable to articulate, but was partially conscious.

He came to America only a few weeks before his admission into the House of Relief on the 9th inst. and no history of previous illness could be obtained from his friends. He was said, however, to have had a convulsion at 5 A.M. on the morning of his admission. He was unconscious on arrival at the hospital.

He had two convulsions, one after his arrival and the other on the morning of the 10th, in which he died.

On admission his temperature was 99° F. In the afternoon of the same day it was 98.6° F., and on the following morning prior to his death his temperature reached 100.6° F.

The autopsy revealed congestion of all his organs, especially lungs and kidneys.

The left hemisphere was generally softened. The occipital lobe and temporo-sphenoidal lobe of this side were quite soft and contained innumerable punctate hemorrhages. There is a firm



thrombus in the internal carotid and middle cerebral of the left side. The thrombus is composed of small round cells, blood, and fibrin. In the examinations made the vessels containing the thrombus were found normal. The vessels of the pia on both sides were found normal. Fragments of the thrombus were carefully stained for micro-organisms with a negative result.

These examinations will be pushed still further and a report made at some future time.

Dr. Ferguson said that some time ago he saw a case of cerebral softening without the presence of a thrombus. Here the lumen of the middle cerebral artery was found to be considerably obstructed by an endarteritis. This partial obstruction, increased in all probability by muscular contraction of the remainder of the wall, had so diminished the arterial supply to the brain as to give rise to the softening. In another case, a woman while lifting a heavy wash-boiler suddenly fell down, and death occurred within forty-eight hours with all the usual symptoms of cerebral apoplexy. Post-mortem examination in her case showed a thrombus in the internal carotid and middle cerebral arteries, without any lesion of the arteries or of the heart.

Dr. Prudden suggested that it would be well to avoid the use of such vague terms as apoplexy; it would be much more definite to speak of cerebral hemorrhage, of cerebral thrombosis, and cerebral embolism when these conditions actually exist.

#### AN EXTREMELY LARGE TUBERCULAR KIDNEY.

DR. A. T. WESTON exhibited a very large tubercular kidney which had been removed from a woman, thirty-seven years of age, who gave a general history of tuberculosis dating back to when she was five years of age. She had had fairly good health up to last November at which time she was seen by Dr. J. L. Hopkins, who found a tumor much smaller than the present specimen. It extended from the brim of the pelvis up to about the fifth rib, and filled both thorax and abdomen, extending beyond the median line to the right. The urine contained a small quantity of albumen and some casts. The principal symptoms for three or four weeks previous to her death were intense nausea, vomiting, and severe pain. At the autopsy, the lungs were found to contain cavities and cheesy nodules; the liver was large, soft, and yellow; the stomach was sacculated owing to pressure of the tumor; the other kidney was normal.

Dr. Ferguson said he had examined the tumor, and found at one or two points on the periphery of this multilocular cyst a few kidney tubules. The ureter was completely occluded by inflammatory material. Scrapings from the interior of the cyst, when stained, showed innumerable tubercle bacilli. Although he had seen a number of tubercular kidneys, this was the largest one.

Dr. George P. Biggs said that he had examined some sections at the periphery, and had found typical tubercular tissue.

#### ABDOMINO-PERITONEAL PREGNANCY.

DR. ALBERT C. STANARD, present by invitation, exhibited a specimen of what he supposed to be an abdomino-peritoneal pregnancy. He had removed this specimen by operation from a woman, twenty-three years of age, who had been married five years, and had had one child about one year after her marriage. About six months after this she contracted a gonorrhœa, which lasted for eight months. About last August she began to complain of headache and backache, but menstruation continued, and she had none of the usual symptoms of pregnancy. On November 13th, the menstrual flow was rather more profuse than usual. On December 17th, as a result of unusual excitement and effort, she was seized with sudden pain and uterine hemorrhage, and for the next month there was a variable flow of blood, and considerable pain in the right iliac and sacral regions. When first seen by the speaker, on March 1st, there was a tumor occupying almost all of the true pelvis, and the uterus was enlarged to about three times the normal size. Cœliotomy was performed, and the Fallopian tube on the right side was found to lie across the top of the tumor, with its end adherent to it. The adhesions were separated, and the tumor removed with the tube and ovary. The fimbriated extremity of the tube is just within the wall of the tumor. The tumor was globular in shape, measured about four inches in diameter, and was filled with clots. An examination by a careful pathologist had failed to show any remains of gestation. He thought it possible that gestation had existed from August to December, and that then the foetus was killed, and since that time had undergone absorption.

Dr. S. T. Armstrong doubted very much if entire absorption of the products of gestation could occur in so short a time. It was more probable that the case was one of salpingitis, and that a hemorrhagic effusion had occurred at the period mentioned.

The President agreed with the preceding speaker, that the time was too short for entire absorption to have occurred.

Dr. Ferguson remarked that the general appearance of the interior of the cyst resembled that of a gestation sac.

#### EMPHYEMA AND SUB-DIAPHRAGMATIC ABSCESS.

DR. E. LE FEVRE reported a case which came to him about one month ago. The patient was twenty-five years of age, and had been well up to about one year before, at which time he had an attack of "the grip." About four months later, he was suddenly seized while at work with a severe pain in the lower part of the left side of the thorax, accompanied by very severe cardiac palpitation. He was carried home, and remained in bed for about three weeks, and during this time he lost about thirty pounds in weight, and had severe chills with some pain in the chest, but the expectoration was scanty and not blood-stained. Suddenly his breath became offensive, and within a few hours there was a gush of offensive pus. From this time on, there was an abundant fetid expectoration, but no bacilli were found in it. At the first examination, from the angle of the scapula to the base of the lungs there was flatness on percussion, loss of vocal fremitus, and an entire absence of all voice sounds. When seen the next day, there was amphoric breathing all over this side. Subsequently, Dr. H. P. Loomis, having found pus with an aspirating needle, inserted a drainage tube.

The President said he had considered the case one of pyopneumothorax. A long needle was inserted just below the angle of the scapula, and at various other points, without drawing pus, but finally, on inserting the needle high up between the scapula and the vertebral column, pus was obtained, and one and a half pints were then drawn off with the aspirator. The patient improved for about one week, and then it became necessary to secure drainage, and a tube was inserted into the pleural cavity near the diaphragm. The sputum became scanty and less offensive, but the patient's general condition was not improved, and he died finally of exhaustion.

DR. WARREN COLEMAN said that, as he had made the autopsy, he would present the specimen, and describe in detail the pathological condition.

The right lung was removed without difficulty, and was normal. The upper lobe of the left lung was free, but the lower was bound

down to the outer and posterior chest wall and to the diaphragm. While trying to break up the adhesions, a gush of pus was noticed to come from under the left lobe of the liver. On lifting up the diaphragm on this side an opening was found leading into the pleural cavity. The finger could be passed through this opening and made to protrude through the chest wall where the drainage-tube had been inserted. A portion of the left lower lobe was cut off, and left attached to the diaphragm. The upper lobe of this lung was found to be normal, and the lower completely atelectatic. No pus was discovered in the lung nor in the pleural cavity, and no part of the lung was gangrenous. On attempting to remove the spleen, a fresh gush of pus was observed, so the liver, diaphragm, stomach, and spleen were removed as a whole. Several small abscesses were found between the liver and the lesser curvature of the stomach, but not involving the structure of either organ. An abscess about two and one half inches long and one inch wide was found externally on the spleen. On the upper surface of the left lobe of the liver, between it and the diaphragm, was another abscess of about the same size, but not involving either organ. The largest abscess of all was bounded above by the left lobe of the liver, to the left by the spleen, and below by the stomach. It had not involved any of these organs except the spleen. On the surface was a pyogenic membrane. The pus had a sickening gangrenous color. Communication of the cavity with the opening in the diaphragm was established through the ulcerated upper portion of the spleen.

Dr. George Biggs said that as it was very rare for pus to originate below the diaphragm and extend upwards into the chest the suppurative process was distinctly connected with the organs in that location; it was more probable that in the case just reported the abscess formed in the chest. This theory was strengthened by the fact that the sub-phrenic adhesions were of comparatively recent formation.

#### CARBOLIC ACID POISONING.

DR. GEORGE P. BIGGS exhibited a stomach showing very extensive eschar on the mucous membrane, as a result of carbolic acid poisoning. The eschar was white and leathery, and involved chiefly the fundus and greater curvature, although quite marked around the pylorus. Strange to say, the patient's lips, mouth,

and œsophagus showed scarcely any traces of the corrosive action of the acid. Strength of solution taken was not known.

PARTIAL OBLITERATION OF THE VERMIFORM APPENDIX.

DR. BIGGS presented an appendix which had been removed from a man who died of chronic alcoholism. The appendix consisted of a small pouch about  $\frac{3}{4}$  cm. in length, and beyond this of a fibrous cord 2 mm. in diameter and  $1\frac{1}{2}$  cm. in length, which, apparently as a result of an old inflammation, had been united by adhesions to the neighboring tissues. The effect of this appendicitis had been to cause a complete obliteration of the lumen of more than one half of the appendix. Sections of the fibrous cord showed under the microscope unstriped muscular tissue, fibrous tissue, and many small round cells.

SUB-DIAPHRAGMATIC ABSCESS FROM BILIARY OBSTRUCTION.

DR. GEORGE BIGGS also presented specimens from a patient sixty-four years of age who was admitted to the New York Hospital March 19th, with a history of syphilis, alcoholism, and malaria. For eight years he had had attacks at intervals of from two weeks to two months, beginning with a sharp chill, and followed by fever and sweating, but without any pain or jaundice. The attacks were preceded by a more abundant flow of pale urine, and followed by a diminution in the secretion of urine, and a darkening of its color. For the last three or four years there had been deep jaundice. Five weeks before his admission he experienced for the first time considerable soreness to the right of the umbilicus, and eleven days before coming to the hospital he had one of these attacks, but this time it was associated with severe pain. On admission his pulse was 88, respirations 24, temperature  $96^{\circ}$  F.—in fact he was nearly moribund. The area of hepatic dulness was found to extend from the fifth rib to two inches below the free border of the ribs, and below this point the distended gall-bladder could be felt. He died rather suddenly of heart failure.

At the autopsy the liver was found to be considerably enlarged, and projecting  $2\frac{1}{2}$  inches below the free border of the liver was the distended gall-bladder. The right thoracic cavity contained 1000 cc. of yellowish fluid containing biliary coloring matter.

Just beneath the diaphragm was another collection of fluid between the upper surface of the liver and the diaphragm, measuring 800 cc. Below the diaphragm, the wall of the cavity was formed by adhesions between the left lobe of the liver, stomach, duodenum, transverse colon, and the side of the gall-bladder. There was also a recent perforation through the centre of the right half of the diaphragm, connecting this cavity with the right pleural cavity. An abscess the size of a hen's egg on the under surface of the liver, at the junction of the right and left lobes, communicated with the abscess between the diaphragm and the liver, and with the fundus of the gall-bladder by an ulcerated opening measuring 2 x 1 centimetre. The cystic, hepatic, and common ducts were very much dilated. In the hepatic duct was a curved, pear-shaped, black calculus, measuring 7 cm. in length and two inches in its largest diameter, the small end projecting downward. The opening of the common bile duct was perfectly normal. The fluid in the abscess cavities contained large numbers of minute black calculi. The large gall-stone probably formed in the gall-bladder and passed through the cystic into the common duct, and back into the hepatic; it probably caused obstruction of both the hepatic and cystic ducts. The rupture into the thoracic cavity certainly occurred only a short time before death.

#### ABSCESS OF THE LIVER.

DR. D. H. McALPIN presented specimens from three cases of abscess of the liver. In the first case, there were multiple abscesses of the liver with perihepatitis, adhesions to the diaphragm, adherent pleura, rupture, and expectoration of muco-pus. Although there was no history of diarrhoea, there were necrotic areas in the intestine, and the amœba of dysentery was found in the intestine. In the second case, there was an abscess of the posterior superior portion of the liver, which was enclosed by adhesions to the diaphragm. It pointed in the hypochondriac region, and the incision was made at this point, and drainage established. The intestines were normal. In this case, there was a history of a "strain" from lifting a heavy weight. The third patient was an Italian with an ulcerating carcinoma of the pylorus. Sections under the microscope showed multiple abscess, and around the portal vein round-cell infiltration and beginning abscess formation.

## SMALL CIRRHOTIC KIDNEYS—ACUTE ANÆMIA.

DR. J. W. BRANNAN presented specimens from a man, forty-seven years of age, who had been taken ill on April 5th with cough and rapid respiration. There was no alcoholic history. On admission he was unable to talk, although not comatose; pulse 125, irregular and weak; respirations 44, temperature 98° F. There were a few râles over the lungs, and a diastolic murmur at the base of the heart. About fifteen hours before death, the temperature was 98° F. in the rectum. At the autopsy the left lung was found adherent throughout; the pericardium was adherent to the heart; the heart was hypertrophied and weighed 16 ounces. There was atheroma of the aorta; the brain was normal except for some anæmia. The two kidneys weighed 3½ ounces, and the urine found in the bladder had a specific gravity of 1009, and contained  $\frac{1}{4}$  per cent. albumen.

## INTESTINAL OBSTRUCTION.

DR. BRANNAN also presented specimens from a case of intestinal obstruction. The patient walked into the hospital yesterday morning complaining of pain in the abdomen. His temperature was 101° F. This morning at four o'clock he went to stool. One or two hours later he was found dead in bed. A hurried post-mortem examination made this evening showed nothing abnormal in the brain or lungs; the kidneys were large and firm, and showed the lesions of chronic diffuse nephritis; the heart was small and the left ventricle thickened. An examination of the abdominal cavity showed chronic peritonitis and some recent exudation of lymph. A portion of the transverse colon was constricted and congested, and its mucous membrane softened. Death probably resulted from this obstruction.

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*Stated Meeting, April 26, 1893.*

DR. H. P. LOOMIS, PRESIDENT.

## ARTHRITIS OF THE KNEE.

DR. THOMAS H. MANLEY exhibited a knee joint which had been removed from a young woman. She had a good family history, and denied having had gout, rheumatism, or syphilis. On January 12th, she contracted a severe cold, and two days

later first began to have pain about the knee joint. On February 1st, it was swollen and acutely inflamed, and her attending physician thought she was suffering from acute articular rheumatism. On March 27th, she was admitted to the Harlem Hospital, and at that time had a pulse of 108, and a temperature of 101° F., and a physical examination showed a slight consolidation at the apex of the left lung. She was profoundly anæmic and prostrated, and her general condition was such that a serious operation was considered inadvisable. There was a small fistula at the inner side of and below the knee, and evidence of insufficient drainage, so better drainage was secured, but without resulting in relieving the pain or in any general improvement. Her condition became steadily worse, and finally was so critical that it was decided to amputate the limb. The operation was done on April 19th. Before the operation her pulse was 160, respirations 44, and temperature 105° F., yet on the following day her temperature had fallen to normal, and from that time on she rapidly improved. The case was considered at first to be one of tubercular disease of the knee, but he had learned subsequently that the patient had been quite dissipated, and that there was some reason for believing that she may have had a gonorrhœal arthritis. The speaker also briefly alluded to a case of arthritis of the wrist which developed shortly after confinement. Here, the child had gonorrhœal ophthalmia, and the husband admitted having had gonorrhœa six weeks before the confinement.

Dr. R. H. Sayre said that, from a cursory examination of the specimen without making a section of the bone, he would look upon the case as one of purulent arthritis. There is apparently no evidence of tuberculosis. He thought if the joint had been opened thoroughly and cleaned out at an earlier stage, amputation might have been avoided.

The specimen was referred to the Microscopical Committee for examination.

TUBERCULAR EMPYEMA; AMYLOID DEGENERATION; ACUTE  
MILIARY TUBERCULOSIS.

Dr. F. FERGUSON presented gross and microscopical specimens of amyloid degeneration. The microscopical specimens were prepared by immersion in a 1-500 watery solution of the dahlia stain, then thoroughly washing in water, and mounting in



a very weak solution of acetate of potash. The liver from this case was very much enlarged, and an examination of some frozen sections of it showed apparently, in addition to the amyloid degeneration, a few tubercles. The kidneys showed a few tubercles, and amyloid degeneration, which in the cortex was confined almost entirely to the arteries, and in the pyramids, to the tubes. There was a history of some thoracic trouble having existed for nine months, and at the autopsy there was found to be a tubercular empyema, and also a tubercular peritonitis.

EXTENSIVE CEREBRAL HEMORRHAGE ; CARDIAC HYPERTROPHY  
WITHOUT DILATATION.

DR. FERGUSON also presented specimens from a case of extensive cerebral hemorrhage. The man was brought to the hospital about ten hours before death. He had a slow, and strong heart action : tremor, more marked on the right side, and shortly before his death he had Cheyne-Stokes respiration, and one severe convulsion. A diagnosis was made of apoplexy. An examination of the brain showed the hemorrhage to be unusually extensive : the septum lucidum had been destroyed ; the third and fourth ventricles were filled with blood, and the hemorrhage had made its way to the surface, so that at first it looked as though there had been a meningeal hemorrhage. The convolutions were much compressed. The vessels at the base of the brain showed well marked atheroma. The vessels of the kidneys were the seat of endarteritis obliterans. The heart was hypertrophied, but there was not that marked dilatation of the ventricles so commonly found in connection with chronic renal disease. There were no valvular lesions, and the heart muscle was in good condition.

DR. FERGUSON also exhibited specimens which had been removed from an Italian, twenty-two years of age. No history was obtainable except that there had been a moderate elevation of the temperature, and extreme dyspnœa. An examination of the heart *post mortem*, showed the mitral orifice contracted to a little less than half an inch, and also sufficient contraction of the segments of the aortic valve to interfere with their proper action. There was also a typical nutmeg liver, and the lungs showed the typical appearance described by Delafield as "the pneumonia of heart disease."

*Stated Meeting, May 10, 1893.*

DR. H. P. LOOMIS, PRESIDENT.

ACCESSORY LIVER AND PANCREAS.

DR. J. S. THACHER showed a pancreas completely encircling the duodenum, and causing slight stricture of its canal. Just above the duodenum was an accessory pancreas, a specimen of which was shown under the microscope. Dr. Thacher also presented an accessory liver, two inches in diameter, and one fourth of an inch in thickness, which had been found by Dr. G. A. Tuttle at an autopsy. It was situated on the surface of the spleen, and intimately attached to it, and was entirely disconnected from the liver. Microscopical examination showed typical liver tissue.

Dr. T. M. Prudden remarked that he had seen during the past winter an accessory pancreas, situated in the lesser omentum.

Dr. George P. Biggs said that he had found an accessory pancreas situated in the muscular and submucous coats of the duodenum, about one half inch from the pylorus.

PACHYMEINGITIS HEMORRHAGICA INTERNA—INTERCURRENT DISEASES IN GENERAL PARESIS.

DR. E. D. FISHER presented microscopical specimens showing pachymeningitis hemorrhagica interna. They were taken from a negro, forty years of age, who was suffering from general paresis. There was an old tubercular cavity in one lung. The speaker said that he desired to call attention to the case (1) because it is generally stated that general paresis is comparatively rare among negroes and Irish; and (2) because it showed the insidious way in which acute intercurrent diseases develop in general paretics. As a matter of fact, general paresis is as common among the two races mentioned as among others, provided their surroundings and mode of life are favorable for its development. Acute intercurrent diseases also change the course of the mental trouble, the mental symptoms returning after the subsidence of the acute disease. It should be an invariable rule to make a careful physical examination of the heart, lungs, and other organs in such subjects.

## PRIMARY CARCINOMA OF THE LIVER, WITH MULTIPLE SECONDARY DEPOSITS.

DR. GEORGE P. BIGGS presented a liver containing multiple new growths. It had been removed from a man, forty-two years of age, who was admitted to the hospital late one evening, and who died before morning. As a consequence, a complete history was not taken, and only a hurried physical examination was made. He had had pain in the right side for three or four months, and had been steadily emaciating, but there had been no gastric symptoms, and he was only slightly jaundiced. A nodule tumor could be very distinctly felt in the abdomen, filling nearly its entire cavity, and on auscultation there was distinct friction over the tumor. A diagnosis was made of carcinoma of the liver. At the autopsy, the tumor was found to be an enlarged liver, which occupied practically all the abdominal cavity except the left iliac region, the lower end of the right lobe being located in the right iliac fossa. The organ measured 31 ctm. vertically, 32 ctm. transversely, and 12 ctm. in thickness in the upper portion of the right lobe. Its weight was 12 lbs. 12 oz. There was slight recent perihepatitis. The liver was everywhere studded with innumerable growths, yellowish, greenish, or whitish in color, in the fresh state, and varying in size from a pin's head to a hen's egg. Many tumors projected from the surface in the form of umbilicated nodules. About 5 ctm. above the lower end of the right lobe of the liver, in its right border, was a marked depression corresponding to the location of a scirrhus growth, 7 ctm. in diameter, which was evidently the oldest growth in the liver. A careful search for a possible primary new-growth outside the liver resulted only in finding three lymphatic glands at the transverse fissure of the liver which were each about  $1\frac{1}{2}$  ctm. in diameter, and evidently contained tumor tissue. The gall-bladder, large gall-ducts, and the alimentary canal were perfectly normal. Specimens exhibited under the microscope showed the growths to be carcinomata. The large scirrhus growth referred to was undoubtedly the primary one, and dissemination probably occurred through the medium of the biliary passages, for many of the gall-ducts seen in the sections in the neighborhood of a tumor tissue show marked proliferation of the epithelial lining, the lumina of some being filled and distended by these cells.

Primary carcinoma of the liver is very rare, but is spoken of in

three forms, viz. : (1) A single nodule, usually in the right lobe ; (2) a diffuse infiltration of the whole liver ; and (3) small nodules along the course of the portal vein. No mention is made in the first variety of the existence of secondary deposits.

SYPHILITIC LESIONS OF LIVER AND LUNG—CEREBRO-SPINAL  
MENINGITIS.

DR. BIGGS next presented the liver and lung removed from a man who died of cerebro-spinal meningitis. There were numerous adhesions over the surface of the liver, a large number of cicatrices, and a general increase in the fibrous tissue with considerable fatty change. The left lung showed a peculiar increase in the fibrous tissue throughout the lower two thirds of the lower lobe, and also through a portion of the upper lobe, so that in the fresh state it felt almost solid. The fibrous tissue was very tough ; there was no crepitation, and practically no aëration of these portions of the lung. There were no cicatricial bands on the surface. The opposite lung presented the same general appearance.

The brain and a portion of the spinal cord from the same patient were also exhibited. They were chiefly of interest on account of the very extensive involvement of the choroid plexuses. The exudation over the base was very thick, while there was scarcely any on the convexity. The lateral ventricles were both distended with purulent fluid, and a similar fluid was found in the fourth ventricle. The same abundant exudation which was found on the choroid plexuses also extended down the whole spinal cord. The patient lived twelve days after developing symptoms of cerebro-spinal meningitis, and during all this time the disease was very active. This may explain the abundance of the exudation. The speaker said that out of ten recent cases, this was only the second in which the exudation had been so especially marked over the base as compared with the convexity.

DIPHTherITIC VAGINITIS.

DR. GEORGE BIGGS also presented a specimen of extensive diphtheritic vaginitis. The patient was admitted to Bellevue Hospital with the statement from her attending physician that she was suffering from alcoholic neuritis. This diagnosis was con-

firmed. On the third day after admission, the nurse reported an offensive vaginal discharge, and examination showed the vagina to be the seat of a diphtheritic inflammation. Her temperature on admission was 99° F. in the morning, and 104° F. in the evening, and this continued for six days, when the evening temperature rose to 105° F. For about twenty-four hours before death she had a profuse diarrhœa. The woman was not in a condition to give a reliable history. Her friends stated that she was a married woman, and that she had been sick for about three weeks previous to going to the hospital. The case was peculiarly interesting in view of the fact that the uterus and appendages were perfectly normal. The entire vagina was covered by a very marked yellowish diphtheritic membrane, but there was no ulceration or stripping off of the membrane. It was limited above by the internal os. She was under observation for eleven days, but nothing abnormal was observed about the throat. At the autopsy it was found that the lower part of the rectum was the seat of a recent diphtheritic inflammation. There was also a fairly advanced tuberculosis of one lung and a slight chronic diffuse nephritis.

A CASE OF CEREBRO-SPINAL MENINGITIS WITH STRANGE  
URINARY SYMPTOMS.

DR. HERMANN M. BIGGS presented specimens from a case of cerebro-spinal meningitis which was admitted to his ward on the night of May 3d. He did not feel ill until noon of that day, then he rapidly became delirious, and at midnight was admitted to the hospital in a comatose condition, and had a temperature of 104°. The temperature varied between 103° F. and 106° F. up to the morning of May 7th, when he died. The first specimen of urine was examined on the day following his admission, and it was found to contain a good deal of blood, which on standing readily subsided to the bottom of the vessel. The clear portion contained considerable sugar. The next day there was apparently a much larger quantity of blood in the urine, but intimately mingled with it. Microscopical examination, however, showed only a comparatively small number of red blood corpuscles. The urine no longer contained sugar. He continued to excrete a considerable quantity of urine of this character up to the time of his death. At the autopsy his bladder was found

distended, the wall thickened, and the mucous membrane the seat of innumerable hemorrhages, and of some superficial erosions. In some places there was a delicate deposit of fibrin on the surface. The process had apparently extended up one ureter and involved the pelvis of that kidney, while the urine in the pelvis of the other kidney was perfectly clear and free from blood. The other lesions were those of cerebro-spinal meningitis, there being an extensive deposit over the base of the brain, and the posterior surface of the spinal cord, chiefly, however, in its lower portion.

The clinical history of this case would lead one to believe there was in addition to the glycosuria which is occasionally found with cerebro-spinal meningitis, a hæmoglobinuria, but the absence of blood or blood-coloring matter from the urine found in one kidney at the autopsy would seem to exclude hæmoglobinuria, and the condition of the bladder would indicate that this organ was the source of the hemorrhage. A few petechial hemorrhages were found in the pleura, and in several places where the skin had been abraded there was a marked tendency to hemorrhage.

LYMPHO-SARCOMA OF THE RETROPERITONEAL LYMPH NODES,  
MESENTERY, AND INTESTINE.

DR. H. M. BIGGS also presented specimens from a case of lympho-sarcoma. The patient's statements were found not to be reliable, but as nearly as could be ascertained he was perfectly well up to last January, at which time he took some medicine for worms, which produced a very profuse catharsis. Soon after this his abdomen became distended and tender, his bowels constipated, and he suffered considerably from colicky pain. On admission he was jaundiced, the abdomen was distended and tympanitic, but not very tender, and the abdominal wall on the right side was thick and hard, and several small nodules could be felt in the substance of the wall at its lower portion. His temperature rarely rose above 100° F. High enemata, saline cathartics, and other similar measures failed to open his bowels, and after being in the hospital for one week it was thought advisable to do an exploratory laparotomy. On opening the abdomen the peritoneum everywhere was found to be intensely injected, and the abdominal wall enormously thickened, and the

seat of a new growth. Near the junction of the jejunum and ileum and also at a point higher up, new growths were found, and the retroperitoneal lymph nodes and mesentery were similarly involved. Further operative measures were therefore abandoned. The patient died on the following day. Microscopical examination of sections from one of the masses found in the intestinal wall, and from the retro-peritoneal lymph nodes showed the new growth to be a lympho-sarcoma which apparently began in the retro-peritoneal lymph nodes, and extended thence to the mesentery and intestinal wall. It involved the mucous membrane and submucous tissue, and also slightly the muscular tissue of the gut.

Dr. J. S. Thacher recalled a similar case he had seen, in which there was extensive infiltration of the mesentery and of the intestine near the head of the pancreas, but which did not involve the pancreas.

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*Stated Meeting, May 24, 1893.*

DR. H. P. LOOMIS, PRESIDENT.

SARCOMA OF THE UTERUS AND OVARY.

DR. GEORGE C. FREEBORN presented a series of specimens illustrating this condition.

The patient, from which this specimen was removed, was admitted to the service of Dr. Bach Emmet in the Woman's Hospital. She was thirty-four years of age, the mother of six children, and had been perfectly healthy up to two years previous to her admission to the hospital. At that time she had a miscarriage and has flowed freely and continuously since.

The specimen which I present was removed by supra-pubic hysterectomy. It measures  $12\frac{1}{2}$  ctm. in length and 7 ctm. across the horns. Growing from the fundus of the organ is a fungoid mass, soft in consistency; on the right side of the body there is an oval-shaped mass, 2 ctm. in length and 11 mm. in width, which projects beyond the surface. Latero-perpendicular section through the uterus shows the fundus capped by a crescentic-shaped zone, 2 ctm. in thickness, made up of roundish masses, reddish in color, imbedded in a soft white tissue. In the right

side of this zone there is a triangular-shaped cavity which communicates with the external surface of the organ, through the above described fungoid mass. This cavity was filled with shreds of necrotic material. The mucous membrane is almost entirely replaced by a zone of tissue composed of red and white nodules of soft consistency, many of which form papillary projections into the uterine cavity.

*Microscopical Examination.*—The zone at the fundus of the uterus and the fungoid mass are round-cell sarcoma with a slight mixture of small spindle cells, both masses showing necrotic changes. The mass at the right side of the organ shows the same histological formation. The mucous membrane is replaced by a new growth of round-cell sarcoma which has infiltrated the muscular tissue to a considerable extent. The surfaces of the papillary projections are necrotic.

SARCOMA OF THE UTERUS AND OVARY, CYSTO-SARCOMA OF  
THE OMENTUM.

This specimen was removed, *post mortem* from a woman fifty-two years of age, who was admitted to the service of Dr. Hanks in the Woman's Hospital. A brief history of the case is as follows: She was the mother of six children; the menopause occurred five years ago. At that time she began to have pain in the right side and her abdomen began to enlarge. Previous to her admission microscopical examination of curettings from the uterus showed sarcoma.

An exploratory laparotomy was made and a tumor, which was diagnosed as a retroperitoneal sarcoma, was found filling the abdominal cavity. No attempt at removal was made. The patient died on the eleventh day after the operation. The autopsy showed general peritonitis and chronic diffuse nephritis.

The first specimen is the uterus and appendages. The uterus is enlarged, measuring 10 ctm. in length and 8 ctm. across the horns. Sagittal section shows the cavity of the organ dilated by an oval-shaped mass  $4\frac{1}{2}$  x 6 ctm., which is growing from the anterior wall. In the fresh state this mass was of a mottled red and white color, and of soft consistency. The left ovary is atrophied. The right is enlarged, cylindrical in shape, measuring 7 ctm. in length and 2 ctm. in diameter. Transverse section through these organs shows them reduced to a soft white mass.



The second specimen is the mass from the omentum. It is oval in shape, measuring 30 ctm. in its long and 16 ctm. in its short diameter. The entire surface is rough, its anterior portion being studded with numerous small cysts which contain grumous blood and necrotic tissue. Longitudinal section shows a spherical-shaped cyst in the central portion, measuring 11 ctm. in diameter, with a smooth internal surface and filled with a reddish-brown fluid. The posterior wall of this cyst is thin and is made up of fibrous tissue; the anterior is thick—5 to 8 ctm.—and is composed of various-sized nodules of a red color, imbedded in a white-colored soft tissue. It also contains several small cysts filled with grumous blood.

This mass was found occupying the lower portion of the abdominal and upper portion of the pelvic cavities, being firmly adherent to their lateral walls, to the fundus of the uterus, and to the enlarged right ovary. Posteriorly it had no attachments. The intestines were found behind the tumor, several coils of the small one being adherent to its upper surface. The tumor was attached to the lower border of the stomach by a short membranous band—the upper portion of the omentum.

*Microscopical Examination.*—The mass projecting into the cavity of the uterus is a small round-cell sarcoma with slight mixture of spindle cells. The ovary and tube show the same structure as the uterus. The tumor of the omentum is a mixture of several kinds of sarcoma. In some places it is small round-cell, in others giant-cell, small and large spindle-cell, and angio-sarcoma. There are numerous necrotic spots and small cysts filled with grumous blood and necrotic tissue.

#### SARCOMA OF THE UTERUS.

This specimen was sent me by Dr. C. Cleveland for microscopic examination.

The organ is enlarged, measuring 14 ctm. in length and 10 ctm. across the horns. Section shows the walls to be much thickened. Growing from the right side of the cavity is an irregular shaped mass 9 x 6 ctm. in its diameters.

*Microscopical Examination.*—The mass growing into the cavity is a round- and spindle-cell sarcoma. The uterine mucous membrane of the uterine cavity above and below the tumor shows adenomatous hyperplasia.

## SARCOMA OF BOTH OVARIES AND TUBES.

These specimens were removed by Dr. G. M. Tuttle and sent me for microscopical examination.

The small ovary is of a flattened oviform shape,  $5\frac{1}{2}$  ctm. in length,  $4\frac{1}{2}$  ctm. in width and 2 ctm. in thickness. The surface is smooth. The tube is slightly enlarged and twisted. The mesosalpinx is much elongated and contains a small thin-walled cyst. Section through the organs show them reduced to a soft, white mass enclosed by a thin fibrous capsule.

The large ovary is oval in shape with a corrugated surface, numerous small cysts being scattered over it. It measures  $12\frac{1}{2} \times 8 \times 7$  ctm. Section shows it to be made up of a soft white mass, the central portion showing necrotic spots. The tube is enlarged, measuring 30 ctm. in length and 27 mm. in diameter. Its surface is covered with adhesions. Longitudinal section shows no sign of a lumen, the interior being composed of a soft white tissue.

*Microscopical Examination.*—Both ovaries are sarcomatous. The character of the cellular elements varies in different portions: small spindle cells, which predominate, small round cells, and large round cells. The stroma in the small ovary is abundant, in the large one scanty. Both tubes are sarcomatous, the cellular elements being the same as the ovaries.

The patient died, on the seventh day after the operation, of what was supposed to be secondary deposits in the lungs. No autopsy was permitted.

## SARCOMA OF THE OVARY.

This specimen was removed from the right side of the uterus by laparotomy. It is the enlarged ovary, oval in shape, with a smooth surface. It measures  $34 \times 18$  cms. Longitudinal section shows a soft white mass enclosed by a moderately thick capsule. In the centre of the tumor there is a good-sized crescentic-shaped cyst, which was filled with a reddish-brown, thick fluid. Smaller cysts are scattered through the rest of the tumor.

*Microscopical Examination.*—The tumor is a small spindle-cell sarcoma, the stroma being scanty.

## FIBRO-CYSTO-ADENO-SARCOMA OF THE OVARY.

The patient from whom this tumor was removed was sixty-six years of age, and had given birth to eleven children. The history

of the growth of the tumor extended over a period of two years. At first it was slow, but during the last two months it was rapid. The specimen was a multilocular cyst, two thirds of which was made up of small cysts with thin walls; the remaining third consisted of a dense triangular-shaped mass, measuring 9 x 8 x 7 cms., the central portion of which was calcified. The internal surface of this mass was composed of small cysts, with moderately thick walls. The gross tumor was not preserved, as it was taken for an ordinary multilocular cyst adenoma. Blocks were removed from various portions of the cyst wall for microscopical examination, and I present slides showing the structure of various portions of the tumor. The dense mass is a cystic fibro-sarcoma; the cystic mass internal to this is a peculiar form of adeno-sarcoma which has been described by Klebs (*Die Allgemeine Pathologie*, zweiter Theil, 1889, p. 748).

#### SARCOMA OF THE OVARY.

This specimen, the right ovary, was removed by laparotomy from a woman twenty years of age, unmarried, who was admitted to the service of Dr. Cleveland in the Woman's Hospital. The history of the growth of the tumor only extends over a period of three months.

The tumor is a bilobed mass, oval in shape, and was attached to the right horn of the uterus by a flat pedicle about 5 centimetres in width. The tumor measures 22 cm. in length, 16 cm. in width, and 10 cm. in thickness. Its surface is smooth. Section through the mass shows it to be composed of a soft white tissue enclosed by a thin fibrous capsule. In the central portion of each lobe there is a small fibro-cystic mass.

*Microscopical Examination.*—Frozen sections from the fresh tumor showed it to be a small round-cell sarcoma, with scanty stroma.

Sarcoma of the uterus and ovary is believed to be a rare form of tumor. Up to the year 1886, Gusserow was only able to collect seventy-three recorded cases of sarcoma of the uterus. I have endeavored to bring the recorded cases down to date, but have given up the task as hopeless on account of the incomplete manner in which many of the cases of tumor of the uterus have been reported. In going over the literature, I find that the favorite method of the English and Americans is to report tumors of the uterus as malignant growths, nothing being given in the report as

to their histological character. It is quite possible that the term "malignant" covers a number of cases of sarcoma.

Sarcoma of the uterus occurs most commonly as a diffuse growth of the mucous membrane. It may occur as a primary nodule in the walls of the organ, in which case it is of a fibrosarcomatous nature, but it is exceedingly rare.

The seventy-three cases collected by Gusserow show that it occurs most frequently between the ages of thirty and fifty; before thirty and after fifty it is quite rare.

The statistics of sarcoma of the ovary are in equally as bad a state as those of sarcoma of the uterus, and from the same cause. Up to 1886, Olshausen had collected thirty-seven cases, and Leopold twelve. Of these forty-nine cases, the majority were spindle-cell sarcoma, only one case being small round cell. Fifty per cent. of the tumors were bilateral. There is but little doubt that many of the recorded cases of fibroma of the ovary have been wrongly diagnosed as such. They should have been classified as spindle-cell sarcoma, which is comparatively common, while fibroma is rare.

#### ANEURISM OF THE MITRAL VALVE.

DR. E. HODENPYL presented a specimen of aneurism of the mitral valve which had been removed from the cadaver of a middle-aged man, who had been treated in the hospital for chronic endocarditis and chronic diffuse nephritis, associated with extreme dropsy. The necropsy showed nothing of interest except the heart. This organ weighed thirty ounces, and on the mitral valve, besides some vegetations, was a small aneurism opening into the auricle.

#### ANEURISM OF THE AORTA PERFORATING INTO THE PULMONARY ARTERY.

DR. HODENPYL also showed a specimen that was removed from a man, forty-three years of age, a plasterer by occupation. He was treated in the Roosevelt Hospital last year for acute pericarditis, and was admitted the last time on April 29th of the present year. Since last November, dyspnoea and palpitation had been increasingly troublesome, and two weeks prior to admission he began to cough. On admission, he was cyanotic, his pulse was 170, irregular and soft, respirations 28, and temperature 102.6° F. The urine was acid, had a specific gravity of 1020, and

contained twenty per cent. of albumen. Physical examination of the lungs was negative. There was a pulsation all over the precordium and in the epigastrium, and the area of precordial dullness was considerably increased. Coarse, scraping double murmur was audible all over the pericardium, but was loudest at the base. Here also the rhythm was very irregular, and was increased by deep inspiration. Well marked precordial fremitus could be detected all over the precordium. The heart's action was occasionally irregular. On the day after admission, the patient died very suddenly. At the autopsy, clear serum was found in the abdominal, pleural, and pericardial cavities, and all the viscera were intensely congested. Both ventricles of the heart were hypertrophied and dilated; the muscle and valves were normal. Just above the sinus of Valsalva was a small aneurism, which had perforated at its centre by a circular opening having smooth edges, and large enough to admit the tip of the little finger. This opening communicated directly with the pulmonary artery. The other vessels were normal.

Dr. J. H. Huddleston asked if there were signs of pericarditis when the patient was admitted, if there were signs of old inflammation about the aperture, and whether the opening was congenital or of old formation.

Dr. Hodenpyl replied that there were no signs of pericarditis, that the opening could not have been congenital, because the ductus arteriosus was situated higher up, and that the opening must have been an old formation, as there was the record of an old pericarditis, and the murmur had persisted for a long time.

#### A SINGLE KIDNEY.

DR. HODENPYL also presented a specimen of a single kidney. It had been removed from a man, twenty-seven years of age, who when admitted to the Roosevelt Hospital on April 15, 1893, gave a history of having had no movement from the bowels for nine days, during which time there had been a good deal of vomiting and headache, but no abdominal pain. On admission, he was well nourished; face flushed; tongue brown and dry, and tremulous; marked tremor of the hands. Pulse was 76, regular and strong; respirations 10, temperature 97.4° F. There was complete suppression of urine. The physical examination was negative. On the following day the respirations fell to 6, he vomited repeatedly, there was considerable muscular twitching, and

troublesome and constant hiccough. The patient was perfectly conscious. He was given an enema, which produced a small, fluid stool. He died that evening, and just before death his temperature was 96.4° F. The cortex of the kidney was found to be covered with numerous red infarctions, which must have interfered with the function of the organ. These infarctions, on microscopical examination, showed signs of degeneration and leucocytic infiltration, but there were no bacteria, nor was there a thrombus of the renal artery. There were no hemorrhagic or petechial spots elsewhere. The cause of the infarctions was obscure. Only one ureteral aperture was found in the bladder.

#### A NEW COTTON SWAB FOR OBTAINING FLUIDS.

DR. W. H. PARK presented an improved swab for use in obtaining specimens of exudate from the throat for examination. It consists of a thin steel rod, the end of which is wrapped with sterilized cotton, and then placed in a sterilized test-tube closed by a sterilized cotton plug. A finer wire with a smaller piece of cotton might be introduced into wounds, or into the intestine when it is desired to obtain some of the contained fluids for the purpose of making cultures. The swab is preferable to the platinum wire, because it does not cut the gelatin plate.

Dr. Hodenpyl said he had used these swabs during the past winter, and had found them very convenient. They keep moist for some time.

Dr. F. Ferguson said that some years ago he had had Meyrowitz prepare for him a case holding twelve short test-tubes, containing agar-agar. These tubes were closed by a sterilized cotton plug, and a platinum needle extended from the plug to the agar-agar. It cost only five dollars. He could not see wherein Dr. Park's swab had any advantage over this.

Dr. Park replied that his case cost only eighteen cents ; that he used cotton rather than a platinum point, because in the case of a struggling child it was much more difficult to use the platinum wire than the swab.

#### AN INEXPENSIVE INCUBATOR.

DR. PARK also presented a model of an incubator, the cost of which would not exceed five dollars. It consists of a double boiler having a piece of lead attached to the bottom of the inner

boiler so as to hold that vessel down during the ebullition of the water in the outer vessel. The boiler is surrounded by an asbestos jacket, and a piece of asbestos covers the lid. Through the centre of the lid passes a thermometer which serves to indicate the temperature within the boiler. The gas regulator consists of a bulb containing alcohol, and connected with a U-tube containing mercury. The boiler rests on an iron support, and a Bunsen burner furnishes the necessary heat.

. . GENERAL TUBERCULOSIS.

DR. F. FERGUSON presented specimens from a case of general tuberculosis. The patient was a man, twenty-eight years of age, who was admitted to the New York Hospital on May 22, 1893. About two years before this, he said he spat up a large quantity of blood, and that during the past year he had frequently expectorated smaller quantities. He had had a cough ever since childhood, but recently it had become much worse, and he had emaciated rapidly. On the day before admission, he had a chill, followed by sweating, headache, pains across the chest, and prostration. There was slight dulness and high pitched breathing over the left apex in front, and subcrepitant and coarse râles scattered over both sides of the chest, but most marked over the left apex and right base. Over the right base posteriorly, there was dulness and slightly diminished voice and breathing. The free edge of the liver could be distinctly felt three inches below the free border of the ribs, and the spleen could be palpated two inches below the ribs. At the autopsy, there were found old peritoneal adhesions, cheesy degenerations of the suprarenal capsule, pigmentation of the stomach, a cirrhotic liver with diaphragmatic adhesions, tubercular tracheitis, tuberculosis of the kidneys and prostate, and miliary tuberculosis and pneumonia in the lungs, one lung having a small cavity in the apex.

SUPERNUMERARY PANCREAS IN THE PYLORUS.

DR. GEORGE P. BIGGS presented a specimen showing a tumor at the pylorus, found in a patient who died of alcoholism. The tumor was ovoid in shape and measured 2 by  $1\frac{1}{2}$  by  $1\frac{1}{2}$  ctm. The mucous membrane covering it was thickened but intact and it projected but slightly into the pyloric orifice. From gross appearances it was thought to be a fibroma but microscopical examination shows that it was a supernumerary pancreas.

Dr. Biggs also presented several specimens showing partial separation of a portion of pancreatic tissue from the head of the gland by the muscular wall of the duodenum. These nodules were each about the size of a pea, were located in the submucous layer of the gut, and projected slightly into the lumen. He stated that this anomaly would be found in nearly one third of all necropsies if carefully searched for.

DR. S. T. ARMSTRONG said he believed this was rather an instance of ectopy—properly inclusion—of glandular tissue, than of supernumerary gland.

Dr. Huddleston asked if there were also supernumerary ducts.

Dr. Biggs replied that ducts were found throughout the tissue, but no specially well marked duct was found, nor could he say where these ducts emptied.

#### OLD APPENDICITIS; VERTEBRAL ABSCESS.

THE PRESIDENT presented specimens taken from an almshouse patient, of whom no other history was obtained than that he could not walk, but could move his legs. There was an old appendicitis that showed a tumefaction of the appendix due to accumulated fecal matter. There was also a tumor over the fourth lumbar vertebra, from which, on incision, a quantity of pus escaped. The bodies of the vertebræ were found to have been eroded, and the accumulated fluid compressed the cord.

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*Stated Meeting, June 14, 1893.*

DR. REGINALD H. SAYRE, VICE-PRESIDENT.

#### STENOSIS OF TRICUSPID, MITRAL AND AORTIC VALVES; EXTENSIVE PERICARDIAL ADHESION.

DR. GEORGE P. BIGGS presented a heart showing the results of very extensive pericarditis and valvular lesions. It had been removed from a woman, thirty-five years of age, who gave a history of attacks of rheumatism for a period of ten years. She was first admitted to the New York Hospital in February, 1893, on account of general anasarca, but after treatment there for one month, she left the hospital very much improved. She was readmitted on May 9th, of the present year, complaining of much the same symptoms—general anasarca and dyspnoea. Examination then revealed a moderate increase in the area of cardiac dulness; the apex beat was in the fifth intercostal space, four and a half



inches from the median line, and along the left of the sternum, and at the base two murmurs could be heard, one systolic, and the other diastolic. At the apex, there was a low, "rumbling" murmur accompanying the systole. There was also very marked pulsation of the veins of the neck, synchronous with the systole. The heart action grew steadily weaker, the anasarca increased, and on June 9th, she died. At the autopsy, in addition to the chronic congestion of all the organs, there were extensive adhesions of the pericardium, in some places fully one centimetre thick. At the apex, was an area,  $1\frac{1}{2}$  centimetres in diameter, where the heart and pericardial sac were firmly united to the chest wall by unusually firm adhesions. The heart was considerably enlarged, all its cavities being more dilated than hypertrophied. The muscular tissue was quite fatty. The adhesions of the edges of the tricuspid valve produced such a narrowing of the orifice that two fingers could not be passed into the opening, and the retraction which had occurred also caused regurgitation. The pulmonary valve was normal. The cusps of the aortic valve showed enormous thickening and rigidity, the cusps being fixed in a semi-closed position, thus producing marked obstruction, and allowing regurgitation. The most interesting lesion was at the mitral valve, where the orifice appeared as a semilunar slit, with its convexity looking toward the left border of the heart, and the opening so small as not to readily admit the tip of the little finger. This stenosis had resulted from very pronounced thickening and retraction of the posterior or outer cusp, and thickening and apparent enlargement of the anterior or inner cusp, the latter falling over so as to completely close the orifice during systole. It was very greatly thickened, and its under surface distinctly concave, its upper surface convex, this shape being due to pressure of the blood during ventricular systole.

The speaker said that he had shown an almost exactly similar lesion of the tricuspid valve during the past winter. As the first attack of rheumatism occurred ten years before death, and as her previous history was good, it is probable that the lesion of the tricuspid originated at or subsequent to that time, and was not congenital.

#### A CYST OF THE MESENTERY.

DR. BIGGS then exhibited a cyst of the mesentery which had been accidentally discovered while examining the organs of a

still-born child for another purpose. The cyst was situated to the right of the median line, between the folds of the mesentery, in the lower portion of the jejunum ; it was oval in shape, measured  $4\frac{1}{2}$  and  $3\frac{1}{2}$  centimetres in its principal diameters, and contained colorless serum. Its walls were formed by the two layers of the mesentery. The vessels passing over it were very much distended with blood, and there were a few enlarged glands in the mesentery at its junction with the under surface of the cyst. He had never seen such a cyst, and was unable to offer any explanation for its occurrence.

#### A WHITE GALL-STONE.

DR. BIGGS also exhibited a very rare variety of gall-stone. It was whitish, perfectly translucent, weighed three grm., and measured  $22 \times 18 \times 16$  mm. ; was ovoid in shape, and presented quite a smooth surface. It felt oily to the touch, and was composed entirely of cholesterine. It was removed from a woman sixty years of age, and was the only stone found in the gall-bladder, which was firmly contracted about it.

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*Stated Meeting, September 27, 1893.*

DR. REGINALD H. SAYRE, VICE-PRESIDENT.

#### CARCINOMA OF THE STOMACH.

DR. J. H. HUDDLESTON presented a tumor of the pylorus which had been removed from a man, forty-nine years of age, a laborer of intemperate habits. He had had good health up to early in 1890 when he began to suffer from pain in the stomach and from nausea. Two or three months later, a swelling was noticed in the epigastrium, and there was also slight emaciation, which was attributed to dyspepsia. When first seen in the workhouse on August 24, 1893, he was greatly emaciated and quite feeble. A tumor could be distinctly felt in the epigastrium to the left side of the median line. Inflation of the stomach with gas showed the organ to occupy apparently its normal limits. Two quarts of water were poured in without causing any distress. The first washing brought away curdled milk which had been taken five hours, along with some dark mucus. He said he had vomited three

or four times a day for several months, but never anything but food and water. There was no vomiting of "coffee grounds" while he was in the hospital. His weight on admission was 95 pounds, but he emaciated rapidly, and died on September 6th. Towards the last, he had very little sleep, but complained of scarcely any pain—only of weakness. The contents of the stomach were tested by the phlorglucin-vanilin test for free hydrochloric acid and a distinct reaction obtained. For five or six days before his death he had a low fever— $100$  to  $101^{\circ}$  F.

At the autopsy, the lower lobe of the left lung was found in the stage of gray hepatization. In the pyloric region of the stomach was a tumor, three inches in diameter, which extended into the pancreas. The points of interest in this case are: (1) Its long duration— $3\frac{1}{2}$  years instead of eighteen months to two years as is the rule; (2) the presence of free hydrochloric acid even to the last.

The tumor appears to be an ordinary carcinoma.

Dr. S. T. Armstrong said he did not think the statements formerly made regarding this test for hydrochloric acid in the stomach and its significance were now accepted as correct. He had himself obtained this reaction for free hydrochloric acid in several cases where the existence of gastric cancer was indisputable.

#### A MYXOMA OF THE NOSE.

DR. ROBERT C. MYLES presented what he considered to be a myxoma of the nose. He had removed it from a man, twenty-three years of age. It measured  $2\frac{1}{2}$  inches in diameter when fresh, and was situated in the left nostril. It nearly occluded the posterior nares. Its external appearance strongly resembled that of a fibroma. The tumor, which had a pedicle about  $1\frac{1}{2}$  inches long, was removed by snaring it off at its base.

#### EXOSTOSIS AND NECROSIS OF THE VOMER.

DR. MYLES also presented a sequestrum removed from the nose of a patient who gave no syphilitic history. He had occasionally had a bad odor from his nose during the past two years, and this seemed to the speaker so characteristic of dead bone, that he made a long and determined search for it. He was finally rewarded by finding this sequestrum in the septum, just above the palate bone, and partially hidden by the mucous mem-

brane. As it did not have the natural shape of the septum, it must have been an exostosis. It was very hard, and showed no tendency to disintegration or spontaneous discharge. In order to remove it from the anterior nares it was necessary to cut it with forceps. The specimen could not be anything but the rostrum or the vomer.

It is difficult to find dead bone in the nose, even with a probe; the most delicate test in his opinion is a cotton-wrapped probe, as the rough edge of the bone catches in the cotton, when a probe would slip past the bone, and leave it undetected.

#### ULCERATION AND PERFORATION OF THE ILIUM.

DR. S. T. ARMSTRONG exhibited a specimen of this condition, which had been removed from a woman, forty years of age, who was first admitted to his service at the Harlem Hospital on August 26, 1893. Her family and personal history were negative. Three days before admission she was taken with nausea and vomiting, followed by diarrhœa. She could assign no cause for her trouble except kicks which she had received on the abdomen from a drunken husband. On admission she vomited all ingesta; the bowels moved sometimes as often as ten times in the twenty-four hours, and the evacuations were watery and contained matter resembling curdled milk. There was abdominal pain, but no tympanites. Her body was covered with cold sweat. With a milk and lime-water diet, and sulpho-carbolate of zinc internally, she improved immediately, and was discharged "cured" in two days. On September 10th she had a slight chill, followed by fever, vomiting, and persistent diarrhœa, although there had been no dietetic indiscretion, and she knew of no cause for the relapse. Her temperature oscillated between  $101^{\circ}$  and  $103^{\circ}$  F. until the 19th, when it fell to normal. During the next two days there was only one movement of the bowels, yet she failed perceptibly, and on the evening of the 21st she died suddenly.

The autopsy showed calcareous nodules in the pulmonary apices. The heart was normal. The peritoneal cavity was filled with sero-purulent matter and liquid fæces, and there was a small, circular, punched-out ulceration in the upper portion of the ilium. There was but little congestion of the intestinal blood-vessels, a few circumscribed patches being noted here and there. There was no other ulceration, nor was there any evidence of a foreign sub-

stance in the rest of the intestine that might have caused the perforation. This perforation was probably due to necrosis, the result of vascular stasis.

*Stated Meeting, October 11, 1893.*

DR. T. MITCHELL PRUDDEN IN THE CHAIR.

REPORT OF THE COMMITTEE ON MICROSCOPY.

The Committee on Microscopy reported that an examination of the specimen of bone from a knee-joint, presented by Dr. T. H. Manley on May 24, 1893, failed to show any evidence of tubercular inflammation, but demonstrated the presence of a periostitis and a slightly marked osteitis, whose etiology could not be determined.

MALPOSITION OF THE FALLOPIAN TUBES.

DR. GEORGE P. BIGGS presented two Fallopian tubes which had been found situated behind the uterus, and firmly united by their fimbriated extremities. There was a free communication between the tubes. The specimen was removed from a woman, twenty-nine years of age, who stated that shortly after a miscarriage, six years before, she began to suffer almost constant pain in the left iliac fossa, and also from dysmenorrhœa and menorrhagia. Six months before coming under observation she is said to have had an attack of pelvic peritonitis. When she was admitted to the New York Hospital she complained of constant pain in the pelvis, and an examination showed a hard mass behind and on each side of the uterus. The tubes were removed by operation, the ovaries being left behind. Each tube was 2 to 2½ cm. in diameter, and their walls about 7 mm. in thickness. Microscopical examination showed the lesions of an ordinary chronic salpingitis.

A CALCULUS IN THE SUBSTANCE OF THE KIDNEY.

DR. BIGGS then exhibited a calculus which had been found in the substance of a kidney. Its presence was not discovered at the autopsy, but the calculus was found in the fragment of the kidney which had been removed for microscopical examination. The subject was a man, fifty-eight years of age, who died of acute

miliary tuberculosis. He gave a history of acute articular rheumatism, but denied all knowledge of any acute nephritic trouble, although an examination of the urine before death showed the presence of albumen and casts. The only other lesions found besides those of tuberculosis were the lesions of chronic diffuse nephritis, and a few small cysts. The calculus was round, 6 mm. in diameter, and completely filled a small cyst in which it was found. It was situated midway between the hilum and the convex border.

#### ACCESSORY SPLEENS IN THE TAIL OF THE PANCREAS.

DR. BIGGS also presented two small spleens which had been found in the tail of a pancreas. The smaller one was 2 cm. in diameter, and was completely enclosed in pancreatic tissue, while the larger one, 2 cm. in diameter, was only half imbedded in it. Microscopical examination of both showed typical splenic tissue.

DR. WARREN COLEMAN presented a specimen of

#### DIFFUSE SARCOMA OF THE MUCOUS MEMBRANE OF THE UTERUS.

About a year ago Dr. James H. McIntosh, of Newberry, S. C., sent me a portion of a growth, removed from the uterus by curetting, for examination. I pronounced it sarcoma, and shortly afterward he performed a vaginal hysterectomy. The uterus was put into alcohol and forwarded to me. On making a vertical section through it the cavity is found to be almost completely filled with a soft, succulent mass of light pink color, closely adherent to the wall all around, but apparently not invading it. As the quantity of the new growth originally sent on for diagnosis was large, the cavity must have been completely filled at the time of the curetting. The external os is patulous, measuring 2.5 centimetres in its lateral and 1.2 centimetres in its antero-posterior diameter. The measurements of the uterus are as follows: Vertical diameter, 12.7 centimetres; depth of cavity, 9.6 centimetres; circumference just below level of Fallopian tubes, 20.5 centimetres; circumference at level of internal os, 14.7 centimetres; thickness of wall at fundus, 1.2 centimetres; thickness of wall midway down, 8 millimetres; thickness of wall just above internal os, 6 millimetres.

The Fallopian tubes are not enlarged, and on gross examination appear to be normal.

*Microscopic Examination.*—I examined portions of the neoplasm, the cervix and part of the vagina, the wall of the body, the fundus, and the Fallopian tubes.

The tumor is found to be composed of large round and spindle cells. Giant cells are scattered here and there throughout the mass. No stroma could be demonstrated, the cells being held together by cement substance. In certain parts of the tumor large blood-vessels are so numerous as to suggest an angio-sarcoma. Small blood-vessels and capillaries are plentiful and traverse the tumor in all directions.

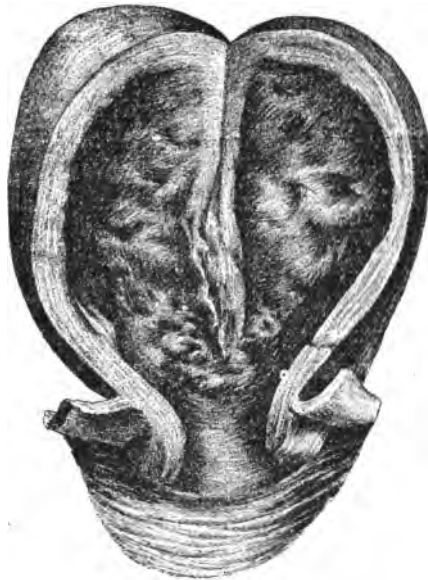


FIG. 1.—Uterus, showing neoplasm nearly filling the cavity.<sup>1</sup>

The cervix is normal except for such senile changes as would be expected in a woman the age of the patient. The epithelial covering is intact. The vagina is healthy.

The wall of the body shows the same changes found in the cervix, but the mucous membrane is wanting. The sarcomatous tissue runs down to the muscle and stops there abruptly. Along the line of junction an occasional giant cell is seen, and there is a slight round-cell infiltration of the muscular tissue at different points.

<sup>1</sup> The drawing was made by Dr. J. M. Byron.

At the fundus there is also an absence of mucous membrane, and the new growth dips down into the muscular tissue of the wall, but does not actually invade it. The whole process is confined to the mucous membrane, as was anticipated at the gross examination from the ease with which the neoplasm separated from the uterine wall. Numerous thin-walled blood-vessels are seen to pass from the uterus into the tumor at this point.

*Fallopian Tubes.*—Close to the uterus both tubes are involved, but in a peculiar way. In several of the reported cases the ex-

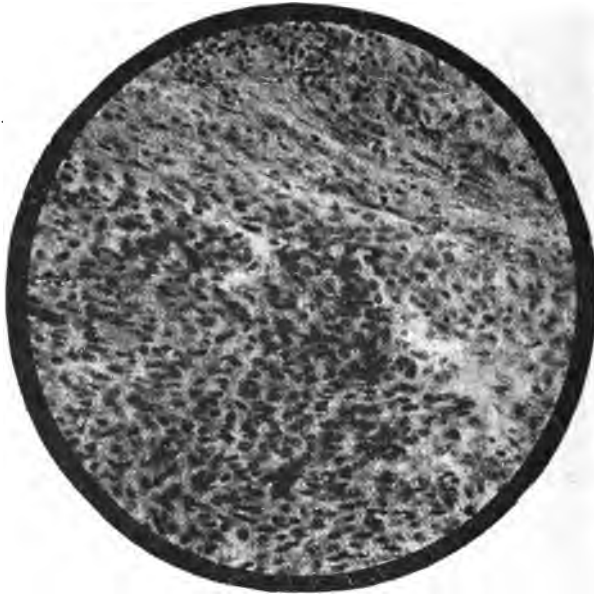


FIG. 2.—Section through fundus, showing neoplasm and uterine wall. Objective, Spencer & Smith  $\frac{1}{4}$  inch homogeneous immersion N. A. 1.35. Projection ocular No. 2. 210 diameters.<sup>2</sup>

tension of the disease process from the body of the uterus to the tubes was in the form of a plug, which in one case projected out at the fimbriated extremity.<sup>1</sup> But here the sarcomatous tissue is found creeping along under the mucous membrane and dislodging it. It is surprising, however, in view of the extent of the growth in the uterus itself, to what a short distance it has gone. In neither tube has it advanced more than eight to twelve millimetres. One of the tubes—I forgot to record whether right or

<sup>1</sup> Simpson, "Contributions to Obstetrics and Gynecology," Sarcoma, Case 2.

<sup>2</sup> The photomicrographs were made by Dr. H. S. Stearns.



left—presents a thrombus composed of sarcomatous elements in a little vessel of its wall.

*History.*—The case occurred in the practice of Dr. B. W. Taylor, of Columbia, S. C. The patient was sixty-seven years old, of American parentage, and had had seven children. Menstruation ceased at fifty-five, and the menopause passed without any unpleasant symptoms. A bloody discharge from the uterus commenced about one and a half years before the time of the operation. She was curetted twice, with temporary relief. The operation

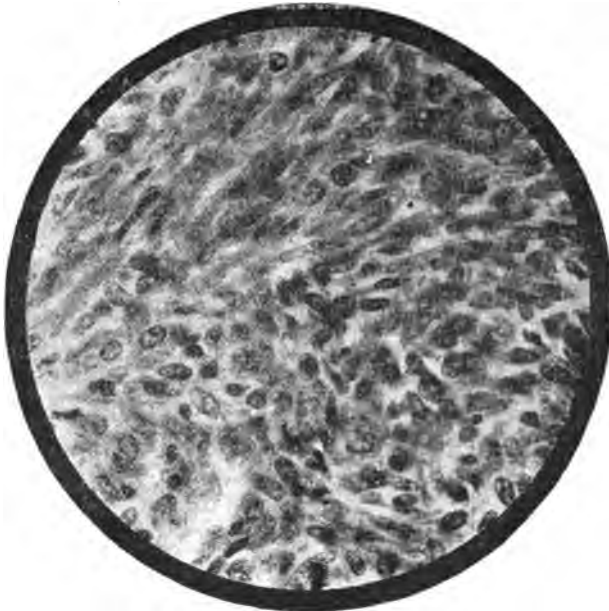


FIG. 3.—Neoplasm. Objective, Leitz 1-12 homogeneous immersion N. A. 1.30. Zeiss projection ocular No. 2. 600 diameters.

was performed October 24, 1892. Shortly after the operation abdominal pains set in, and two weeks before her death the bloody discharge returned. On January 26, 1893, she became paralyzed on the left side, and passed into a comatose state, which gradually deepened until she died, three days later. No autopsy was obtained, but an examination before death revealed a tumor occupying the right iliac region, measuring 10 by 5 centimetres, and another below the umbilicus, measuring 15 by 7 centimetres. The vaginal roof was filled with a soft growth, easily breaking down and bleeding freely on manipulation.

According to M. Terrillon, uterine sarcomata, from a pathologic point of view, present themselves in three varieties : 1. Sarcoma of the mucous membrane. 2. Interstitial sarcoma. 3. Cystic sarcoma.

The interstitial occurs in two forms—the circumscribed, which is often pediculated, and what he terms the *gigantesque*, where there is an enormous hypertrophy of the uterus. In the cystic form, the cysts have thick walls and often contain bloody liquid.<sup>1</sup> I can find no statement as to the relative frequency of the different varieties.

Sarcoma of the uterus is so commonly stated to be a rare disease that I undertook to look up the literature of the subject. Many writers say that less than one hundred cases have been recorded. But as early as 1870, Güsserow had collected sixty-two cases, and in 1874 A. R. Simpson added four to the list. I have found forty-five cases reported during the last five years diagnosed microscopically as sarcomata, and a considerable number in the same period under such headings as “soft fibroid,” “fibro-cysts,” and “recurrent fibro-cystic tumors of the uterus,” which, as the history clearly shows, should be classed with the interstitial or cystic sarcomata of Terrillon. I shall cite one or two such instances. The author says : “The tumor was a fibro-cyst, and contained large cystic cavities. It presented rather an œdematous, spongy condition. . . . The hemorrhage was alarming on account of the extremely vascular nature of the tumor.” The uterus had enlarged in eight months to its size at full term. No microscopic examination was made. In another case, the tumor rose as high as the umbilicus, and had grown to this enormous size in six months. Here the tumor is said to be fibro-cellular, and not wholly fibrous, but the author records it under the title of a “fibro-cyst” without waiting for a microscopical examination. These and hysterectomies for an “interesting pathological condition,” or “malignant disease of the uterus,” are the headings that one encounters in reviewing the subject.

When we take into account, also, the recurrent fibroids and fibro-plastic tumors of the earlier writers, and the fasciculated cancers of Rokitansky, the number of sarcomata of the uterus will be materially increased, and we shall find it not such a rare pathologic condition. Thomas<sup>2</sup> says “that many cases have

<sup>1</sup> *Gaz. des Hôp.*, Paris, 1890, lxiii., 1269.

<sup>2</sup> Thomas on the *Diseases of Women*, 4th edition, p. 539.

been regarded as cancer, and not a few of supposed fatal fibroid or polypus have been unquestionably of this affection."

#### ANEURISM OF THE THORACIC AORTA.

DR. E. HODENPYL presented for Dr. Huntington specimens taken from a dissecting-room subject. They represented a fusiform aneurism of the aorta just at its junction with the heart, and an aneurism of the thoracic aorta which he understood had ruptured into the thoracic cavity, and had also passed through the diaphragm into the abdomen. The cause of death was unknown, but as there was a fracture of the skull, it is quite probable that he met a violent death.

Dr. George P. Biggs remarked that there might have been an opening formed in the diaphragm as a result of post-mortem digestion. He had recently seen a case in which an opening about three inches in diameter was made in this way.

#### INTESTINAL OBSTRUCTION FROM TWISTING OF THE BOWEL.

DR. HODENPYL then presented a specimen removed at autopsy from a man who had had symptoms of intestinal obstruction. The patient was a laborer who, while over-heated, drank a large quantity of ice-water. He was immediately seized with abdominal pain and vomiting. After remaining at home in this condition for two days, he was admitted to Roosevelt Hospital. On admission, there was severe abdominal pain and vomiting, moderate temperature, and an exceedingly feeble pulse. A diagnosis was made of intestinal obstruction, but his condition was such that it was not deemed advisable to operate. He died about four days later. At the autopsy, all the organs except the intestines were normal. The appendix was found bound down behind the cæcum, and there was evidence of a small perforation. The principal lesion consisted in a twist of the small intestine about two feet above the ileo-cæcal valve. The intestine for some distance above this point was congested, and very much distended with fluid fæces.

*Stated Meeting, October 25, 1893.*

DR. H. P. LOOMIS, PRESIDENT.

#### DUODENAL ULCER WITH ABSCESS.

DR. GEORGE P. BIGGS presented such a specimen which was found at autopsy on a female, aged twenty-seven, who died of

acute general peritonitis and intra-peritoneal abscess, the result of septic endometritis. Three weeks before admission to the New York Hospital, she had a miscarriage during which she lost considerable blood. This was followed by profuse vaginal discharge, irregular chills, fever, and severe abdominal pain with tenderness and distension, for one week. Discharge then ceased almost entirely but she developed, in addition to the previous symptoms, sweating, cough, dyspnoea, vomiting, and diarrhoea.

Examination at time of admission to the hospital showed a distended tympanitic abdomen, not very tender owing to almost moribund condition of the patient. The cervix was lacerated, but the internal os closed. Uterus seemed fixed. Subcrepitant râles were heard all over the chest. She lived but four days, during which time her temperature varied from  $100^{\circ}$  to  $108^{\circ}$  F., and pulse from 120 to 150.

At autopsy both large and small intestines were found enormously distended and adherent to each other and the abdominal wall by recent adhesions. In the left inguinal region and extending to the median line in the hypogastric region, there was found a cavity about the size of an orange filled with thin faecal pus. The walls of this space were formed by the left horn of the uterus, left broad ligament, small and large intestines, and peritoneum of anterior abdominal wall, which were united together by fairly firm adhesions. This space communicated by two openings, each about one by one half centimetre, with the sigmoid flexure, by one similar opening with the small intestine, and also by a large opening with an abscess cavity in the *cul de sac* of Douglas.

The uterus was slightly enlarged and the endometrium at the placental site covered with a diphtheritic membrane. The Fallopian tubes were moderately enlarged but contained only a very small amount of pus.

In the posterior wall of the duodenum, just beyond the pylorus, was a circular ulcer 1 cm. in diameter, with smooth, rounded, firm border, communicating with an irregular tortuous sinus, 5 cm. in length and 1 cm. in diameter, running along the upper border of the pancreas 6 cm., and terminating in an abscess cavity about 5 cm. in diameter, the walls of which were formed by the diaphragm above and behind, the upper border of the pancreas below, the posterior wall of the stomach anteriorly, and the inner surface of the spleen externally. There was no communication

between this abscess and the general peritoneal cavity, though the adhesions of coils of intestine about it were numerous and suggested a possible extension of inflammation through the wall.

Other lesions of importance were broncho-pneumonia, pulmonary œdema, and chronic diffuse nephritis.

Dr. Biggs said he considered the peritonitis and intra-peritoneal abscess to be secondary to septic endometritis and salpingitis. Primary ulceration of the intestine could be excluded, as all the perforations with the exception of the one in the duodenum were very clearly from without inward. Entire absence of lesions of the mucous membrane except at points of perforation, all three of which were into a single cavity, would also be against ulceration beginning in the mucous membrane. The softened semi-necrotic condition of the intestine surrounding the abscess explains the ease with which perforation was produced at multiple points and the pus discharged into the intestine, fæcal matter finding entrance into the abscess cavity by the same channels.

The abscess connected with the duodenal ulcer had produced only a slight local peritonitis and apparently had no ætiological relation to the general peritonitis or the fæcal abscess. Perforations of the duodenum are usually of the anterior wall, and produce death quickly from shock or from acute general peritonitis. The firm, smooth, rounded border of the ulcer in the specimen presented would indicate comparatively long duration. It is of the so-called "simple" variety, the ætiological factors concerned in their production being probably the same as those active in the production of similar gastric ulcers.

#### CARCINOMA OF THE STOMACH AND PERFORATION OF THE DUODENUM.

DR. BIGGS also presented a specimen showing carcinoma of the stomach and duodenum with perforation of the duodenum at a point not invaded by the new growth. It was found at autopsy on an Italian woman aged about fifty, who died a few hours after admission to Chambers Street Hospital. The body was extremely emaciated and abdomen distended, tense, and tympanitic. A large amount of gas escaped on opening the peritoneal cavity. There was only a slight general peritonitis, and comparatively little fluid in the peritoneal cavity.

The pyloric end of the stomach for a distance of 6 cm. from

the pyloric ring was firm and rigid, the wall being  $1\frac{1}{2}$  cm. in thickness and evidently indurated throughout with tumor tissue. The internal surface was smooth, distinctly fibrous in consistence, and devoid of ulcerations. There was no obstruction at the pylorus though it was equally invaded by the tumor tissue. The stomach was not dilated. With the exception of an area in the anterior wall  $2\frac{1}{2}$  cm. in diameter, located just beyond the pylorus, the first 6 cm. of the duodenum presented the same appearance as the pylorus save that the wall was only  $\frac{3}{4}$  cm. in thickness and the mucous membrane not so completely destroyed. The portion of the anterior wall not involved was almost membranous in thickness, apparently purely fibrous in structure, and in its central portion there was found an oval perforation measuring 5 by 3 millimetres. No adhesions had been found to neighboring tissues. Malignancy of the growth was clearly shown by extensive invasion of the tissues behind the pylorus and duodenum, the lesser and the greater omentum, the latter being drawn up into a hard cord parallel to and attached to the greater curvature of the stomach. Two small whitish points in the left lobe of the liver, just beneath its capsule, had the appearance of metastases.

Microscopical examination of the pylorus shows that the mucous membrane and submucous layer have been completely replaced by a thick layer of fibrous tissue containing a comparative small number of alveoli filled with epithelial cells of small size. Distinct alveoli are more numerous in the deeper parts. Portions of the fibrous tissue are quite dense, while other portions are rich in ovoid and spindle cells.

The entire thickness of the muscular wall is infiltrated with similar tumor tissue, which, however, contains less fibrous tissue. Typical alveoli filled with epithelial cells are comparatively few in number, but sufficient for a positive diagnosis of carcinoma. The blood supply of the tumor tissue is very scanty. The gross as well as the microscopical appearances of the inner surface of this tumor suggest an attempt on the part of nature to completely heal over the large ulcerated surface which must have existed in an earlier stage of the growth. The history of the case must have extended over a long period, but unfortunately nothing could be learned regarding it.

The two minute points in the liver have the structure of medullary carcinomata, in which the cells are rather small and the alveoli delicate.

The cause of the extreme thinness and fibrous character of the uninvolved portion of the duodenum appears to have been lack of sufficient blood supply, the circulation through the surrounding parts being interfered with by the deposit of dense, fibrous, carcinomatous tissue. The superior pyloric branch of the hepatic artery mainly supplies this area and probably was compressed or occluded by the growth.

LESION OF THE BLADDER PRODUCED BY THE DISTOMA  
HÆMATOBIUM BILHARZII.

DR. THACHER presented a portion of a human bladder exsected at St. Luke's Hospital a few days ago by Dr. B. Farquhar Curtis, and sent to the laboratory for a diagnosis of the nature of the tumor.

When seen after immersion in alcohol, the mucous surface appeared, as now, intensely congested, and presented low nodular elevations. One in particular is noticed,  $\frac{1}{2}$  inch in diameter, and having a rough surface like that of a papilloma.

Stained sections were examined with the microscope, and after the first few examinations a preliminary report was sent stating that no neoplasm had been found, nothing but inflammatory changes. On examining sections from the above mentioned nodule, however, unusual appearances were noticed. Papillary outgrowths were seen, covered by a thickened epithelial layer, which also subdivided them by frequent indippings. At these spots there were abundant leucocytes, extremely distended capillaries, and many clusters of oval bodies resembling the eggs of the distoma hæmatobium Bilharzii. These ova are from 80 to 120  $\mu$  in length, from 30 to 50  $\mu$  in width, oval, and with a sharp short projection at the smaller end. The outline is thin but distinct, the contents of some finely, of others coarsely, granular; in some filling the shell, in others leaving a space just inside the shell, particularly at the ends. In some the granules are evenly distributed, in others there is a distinct circle of them at the centre of the ovum. They lie sometimes just beneath the epithelium, and again 2 mm. from it.

Adjacent portions of the bladder-wall show inflammatory infiltration, not entirely uniform in distribution, marked congestion, and many tubercle-like nodules. These last are about  $\frac{1}{2}$  or  $\frac{2}{3}$  mm. in diameter, are surrounded by a zone of crowded leucocytes, and

made up of variously shaped connective-tissue cells, with scant fibrous material, giant cells, and a few leucocytes. The giant cells are rather irregular in shape, with many nuclei variously disposed. There are rarely any necrotic centres to the nodules or the giant cells. There are usually present in the nodules several irregular lines of striking refractive power, often surrounding open spaces, and supposed to be shrivelled shells of the ova. Occasionally a shell is found of the regular oval shape. The giant cells are very commonly closely applied to these.

The inflammation extends hardly at all into the muscular coat. The superficial epithelium, where retained, is thickened, but is for the most part lost.

On comparing these appearances with the descriptions given by Bilharz,<sup>1</sup> Griesinger,<sup>2</sup> Zancarol,<sup>3</sup> Harley,<sup>4</sup> Brock,<sup>5</sup> and others, there can be little doubt that the ova are those of the distoma hæmatobium Bilharzii or Bilharzia hæmatobia. This diagnosis having been made, it was confirmed by learning that the patient had been a British soldier, and was eight years ago stationed in Cairo, and that hæmaturia had been a prominent symptom in his case for the past three years. Notwithstanding the remarkable prevalence of this parasite in various parts of Africa and the neighboring islands, it has been but rarely observed in Europe,<sup>6</sup> and I know of no case reported in this country, though I am informed that the eggs have been recently found in Chicago.

It is noteworthy that the bladder symptoms in this patient did not appear until five years after he left Egypt. But Dr. Norman Moore reports two cases<sup>7</sup> observed in England, in each of which the trouble first manifested itself sixteen years after the patient left the country, where he had undoubtedly been infected.

In regard to the tubercle-like nodules in this specimen, it is interesting to compare the observations of Miura<sup>8</sup> and Laulanié,

<sup>1</sup> *Zeitschrift für Wissenschaftliche Zoologie*, IV., 1853, pp. 59, 72, and 454.

<sup>2</sup> *Archiv für Physiologische Heilkunde*, XIII., 1854, p. 561.

<sup>3</sup> *Transactions of the Pathological Society of London*, XXXIII., 1882, p. 410.

<sup>4</sup> *Medico-Chirurgical Transactions*, XLVII., p. 55; LII., p. 379; LIV., p. 47.

<sup>5</sup> *Journal of Pathology and Bacteriology*, II., October, 1893, p. 52.

<sup>6</sup> Brandt, *Gazette Hebdomadaire de Méd.*, XXVIII., 1891, p. 382; and *Lyon Médicale*, LXVII., 1891, p. 449.

Norman Moore, *St. Bartholomew Hospital Reports*, XXI., p. 89.

Roberts, *Urinary and Renal Diseases*, 4th Ed., p. 652.

<sup>7</sup> See above.

<sup>8</sup> *Virchow's Arch.*, CXVI., p. 310.

<sup>9</sup> *Comptes Rendues*, XCIV., p. 49.



who describe similar results from the presence of trematode and nematode eggs.

A LARGE RENAL CALCULUS.

DR. H. P. LOOMIS presented a calculus, three inches in length by two in thickness, which had been removed recently by Dr. L. A. Stimson from a young man, nineteen years of age, whose symptoms of calculus dated back about three years. He gave a history of attacks of pain on exertion, of frequent micturition, and of passing dark and bloody urine. On account of his age and family history, it was supposed at one time that his symptoms might possibly be due to tuberculosis, but no bacilli could be found in his urine. Repeated examinations of the urine at different times showed the presence of albumen, pus, blood, and granular and hyaline casts. At the operation, the left kidney was found normal in size and structure, yet this large stone was lying loose in the pelvis of the kidney. It was removed, and the kidney sewed up and replaced. In about ten days, the patient was up and around. The outer crystalline portion of the calculus had been examined, and found to consist of oxalate of lime.

The chief points of interest in the case are : (1) The size and general appearance of the calculus ; (2) the age of the patient ; (3) the fact that oxalate-of-lime calculi are much less frequent than those composed of uric acid ; (4) the quick recovery of the patient ; and (5) the fact that the kidney itself was not diseased.

Dr. Morris, of London, in a recent paper, reports the results of his examination of all the calculi in the Hunterian Museum—the largest collection of the kind in the world. He states that the calculi occurring in childhood consist almost always of urate of ammonia, those found in early adult life are composed almost uniformly of uric acid, while in later life oxalate-of-lime calculi are the most common.

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*Stated Meeting, November 8, 1893.*

DR. H. P. LOOMIS, PRESIDENT.

DR. G. C. FREEBORN presented slides illustrating  
VAN GIESON'S PICO-ACID FUCHSIN AS A SELECTIVE STAIN FOR  
CONNECTIVE TISSUE.

In 1889 Van Gieson<sup>1</sup> described a method of staining the peripheral nerves and sections of the central nervous system with

<sup>1</sup> *N. Y. Med. Jour.*, July 20, 1889.

a mixture of picric acid and acid fuchsin. He prepared his staining fluid by adding a saturated aqueous solution of the acid fuchsin to a saturated aqueous solution of picric acid until a deep garnet-red colored fluid was obtained. This staining fluid stained the ganglion cells, axis cylinders, neuroglia, and sclerotic areas red, myelin yellow.

Ernst<sup>1</sup> has used this fluid for staining the central nervous system and recommends it highly. This recommendation is seconded by v. Kahliden.<sup>2</sup> Ernst<sup>3</sup> also found it a useful stain for hyalin degeneration, which is stained deep red. This reaction for hyalin has been confirmed by v. Kahliden,<sup>4</sup> who also found that hyalin and colloid could be differentiated in the same section; hyalin staining a deep red, while colloid is but slightly tinged or is stained yellow.

Van Gieson's fluid was not made up with any definite proportion of the acid fuchsin solution, consequently the results obtained with each new sample of the fluid differed from those obtained with the previous ones. In order to fix the proper amount of acid fuchsin to be added to the picric-acid solution, I commenced a series of experiments. While conducting these experiments I found that the acid fuchsin showed a selective action for fibrillated connective-tissue fibres, staining them a bright red. This led me to try the action of the staining fluid on other than nervous tissue, and I found that in all organs the connective fibres always gave the same reaction—they were, no matter how fine, stained a bright red color.

As the results of my experiments I have succeeded in establishing the following formulæ for the staining fluid: For connective tissue the proportions giving the best results are 5 c.c. of a 1-per-cent. aqueous solution of acid fuchsin to 100 c.c. of a saturated aqueous solution of picric acid. For sections of the central nervous system the proportion of the acid fuchsin has to be increased and that of the picric acid diminished. The elements in this tissue stain more slowly, consequently the prolonged action of the picric acid removes the hæmatoxylin from the nuclei. The proportions of the staining agents that have given me the best results are 15 c.c. of a 1-per-cent. solution

<sup>1</sup> *Virchow's Arch.*, CXXX., 1893, p. 279.

<sup>2</sup> *Centralbl. f. Allgem. Pathol. u. pathol. Anat.*, IV., 1893, p. 456.

<sup>3</sup> *L. c.*, p. 377.

<sup>4</sup> *L. c.*, p. 457.

of acid fuchsin to 100 c.c. of a half-saturated solution of picric acid.

Sections of tissues hardened in Müller's fluid or mercuric-chloride solutions—alcohol hardening does not give as brilliant results—are first deeply stained in hæmatoxylin (v. Kahlden recommends alum carmine) and then well washed in water. They are then placed in the picro-acid fuchsin fluid for from one to three minutes. Sections of the central nervous system require fully three minutes, those from other organs, as a rule, require only one minute. After removing the sections from the staining fluid they are washed in two alcohols. I find that the addition of a small amount of picric acid to the second alcohol increases the brilliancy of the yellow stain. The sections are cleared in oil of *origanum cretici* and mounted in balsam.

This staining fluid, when used as above described, stains connective-tissue fibres a bright red; protoplasm, muscular tissue, and red blood-cells, yellow. The hæmatoxylin stain in the nuclei is usually changed in color; sometimes it shows purplish-red, other times black.

I present the following sections in illustration of the action of this staining fluid: Normal spinal cord, cerebellum, syringomyelia, and tabes, in which the tissue elements are stained as described by Van Gieson. As illustrating its action on connective tissue, pig's liver, in which the connective-tissue bands between the lobules are brought out sharply even to the naked eye; human liver, human kidney, human prostate gland, in which there is a sharp differentiation between the smooth muscle and the connective tissue. Human skin; in this preparation the deep-red papillæ stand out sharply against the yellow-colored epidermis. Corpus luteum of pregnancy. Carcinoma of the mamma. Large spindle-cell sarcoma. Fibro-myoma of the uterus, in which there is a sharp differentiation between the smooth muscle and connective tissue. Intra-cartilaginous development of bone; this section gives the most brilliant picture of the series. The matrix of the hyaline cartilage is stained a light purple color, the cells yellow with purplish nuclei; the calcification zone is of a much more deep purple as well as the cartilaginous remains enclosed by the new-formed bone, which is of an intense red; the connective tissue is of a lighter shade of red than the bone, and the blood cells bright yellow.

*Appendix.*

Since reading the above, Kantorwicz<sup>1</sup> has published the results of his use of the staining fluid. He finds that the proportion of the acid fuchsin added to the picric acid is of importance, and gives the following formula of the solution used in the laboratory of Dr. Schürhoff, in Frankfort-on-the-Main: Saturated solution of picric acid 150 parts, saturated solution of acid fuchsin 3 parts.

He recommends that the section be stained in Delafield's hæmatoxylin for half an hour and then in the picro-acid fuchsin for from three to five minutes. He has also found the stain useful for tumors, the nuclei staining a purple, protoplasm bluish-yellow, necrotic tissue yellow, connective tissue red. In carcinoma he found that the connective-tissue fibres between the cell-nests were brought out sharply. He also recommends the stain for cell inclusions. The inclusions stain darker than the protoplasm and stand out sharp.

The President asked with reference to the permanency of the stain.

Dr. Freeborn replied that he had had some specimens upwards of two years, and the coloring had not faded. Sometimes prolonged immersion in the oil of origanum would bleach out the acid fuchsin.

**CARCINOMA OF THE CARDIAC ORIFICE OF THE STOMACH.**

DR. E. HODENPYL presented a specimen of carcinoma of the cardiac orifice of the stomach, which had been removed from a case in which there were some unusual symptoms during life. A man was found in the street spitting blood. He was brought to the Roosevelt Hospital in an ambulance, and died in about fifteen minutes. Just before his death he vomited a large quantity of fluid blood. At the autopsy, it was noted that he appeared to be about sixty years of age, and possessed an unusually good physical development. All the organs were exceedingly pale. The stomach and upper portion of the small intestine were greatly distended with clotted blood, and the stomach was filled with a clot having the shape of this organ. An ulcerating carcinoma measuring 4 x 3 inches completely encircled the cardiac orifice, and the opening only admitted the tip of the finger. The head

<sup>1</sup> *Centralb. f. Allgem. Pathol. u. pathol. Anat.*, October 31, 1893.

of the pancreas was also the seat of an ulcerating carcinomatous mass. The interesting point in the case was the entire absence of emaciation.

#### HYPERTROPHIC CIRRHOSIS OF THE LIVER.

DR. HODENPYL also presented specimens from a case of hypertrophic cirrhosis of the liver. The patient was a man thirty-eight years of age, who, although very intemperate, had been in fairly good health up to three months ago, at which time he began to have jaundice and anasarca. Subsequently he complained of nausea and headache, and he developed ascites. On admission, two days before his death, there was extreme abdominal dropsy. He was tapped, and a large quantity of fluid removed. He then passed into a condition of stupor which quickly deepened into a coma from which he never roused. At the autopsy, the principal object of interest was the liver, which weighed nine pounds. It was very rough, jaundiced, and cut like paraffine.

A section of the liver was exhibited under the microscope. It had been stained with Van Gieson's picro-acid-fuchsin, and showed the connective tissue well.

#### CONGENITAL SYPHILIS.

DR. R. G. FREEMAN presented specimens from an infant, about six weeks old, who died in the Foundling Asylum. It was in poor condition when admitted on October 17th. On October 27th, there was slight dulness over both lungs posteriorly, the respirations were 90, the pulse 150, and the evening temperature 101.4°F. For the next three days the respirations remained about 90, and the temperature, though elevated, did not exceed 101.5°F. A diagnosis was made of pneumonia over the posterior portion of both lungs, and there was a suspicion of tuberculosis. At the autopsy, it was found that the posterior portion of all the lobes of both lungs was consolidated in a peculiar manner, and that the liver was the seat of numerous small nodules resembling tubercle. A microscopical examination of these showed them to be small gummata. The other portions of the liver showed marked fatty degeneration.

#### MALFORMATION OF HANDS AND FEET.

DR. FREEMAN also exhibited specimens taken from an infant two-months old, who had suffered from marasmus. All the fingers

of the left hand were webbed, and there was a rudimentary finger. Each foot had six toes, and four of these were webbed.

BEVAN LEWIS'S STAINING FOR GANGLION CELLS.

DR. IRA VAN GIESON presented specimens showing the results obtained with Bevan Lewis's method of staining ganglion cells in the cortex.

He said that the fundamental importance of technical methods was nowhere better shown than in the successive eras of development of the anatomy of the nervous system. Every important advance in this department had had for a basis some valuable improvement in instruments or in staining. To-day, we know that the cortex is one vast wilderness of processes, protoplasmic and neural, derived from the ganglion cells. The ganglion cell had received rather tardy recognition from biologists. This cell consists not only of protoplasm and nucleus, but is a very complex cell. We are beginning to homologize all these intricate parts of the ordinary cell in the ganglion cell, and as a result of regarding the ganglion cell from this standpoint may be instanced the brilliant work of Hodge, who has been able to formulate a sort of mechanical equivalent for the work done by a ganglion cell during fatigue and the recovery after fatigue.

In view of all these rapid advances in our knowledge of this cell, both as to its form and physical structure, we can realize how imperfect are the methods by which we endeavor to ascertain the more delicate changes in cortical pathology. The conventional method is to harden large masses in Müller's fluid. This very crude—perhaps even worthless method—only shows the cell body of the ganglion cell. Müller's fluid was long ago shown to be a very poor preservative of the ganglion cell; the shape, processes, etc., are not shown at all in a specimen thus prepared. In the specimens stained according to Bevan Lewis's method, on the contrary, the structure of the protoplasm and nucleus is nearly perfect. The cortex is so impervious to fluids that in large masses active degeneration takes place in the interior of the specimen before the fluid reaches this part. Professor Donaldson has found that portions of the cortex increase in volume twenty-five per cent. during their immersion in Müller's fluid, probably because the myelin and the ganglion cells both absorb water from the fluid.

The method described by Bevan Lewis in his book, and also

published in the *Journal of Insanity* for July, 1892, is very simple. Frozen sections are made from the cortex; these are transferred to a one-fourth-per-cent. solution of osmic acid for ten seconds; washed in water, and stained for half an hour or one hour in a one-fourth-per-cent. solution of anilin blue-black. Then the specimens are dried overnight on a slide, or more quickly in an oven. The freezing is quite simple at the present time, because liquefied carbonic-acid gas is now readily obtained. Specimens may be frozen with it in half to one minute in a freezing microtome provided with a shallow chamber.

The cerebellum and the spinal cord do not behave well with this method; the former becomes fragmentary, and the myelin of the spinal cord swells up in the osmic-acid solution.

Dr. Freeborn said that anilin blue-black was an old and favorite stain with Bevan Lewis, who many years ago published a method which showed the ganglion cell much more sharply than had been done up to that time. The plan was to overstain the specimens in anilin blue-black, and then to place them in oil of cloves and chloral until, when viewed under the microscope, the intercellular substance was found to have been bleached out. He had himself prepared a number of very satisfactory specimens in this way; he thought, however that acid fuchsin would act very similarly to the anilin blue-black, and would probably give a more brilliant stain. The anilin blue-black stain is most admirably adapted to photographic work.

#### TUBERCULAR APPENDICITIS.

DR. H. E. STEARNS presented specimens from an obscure case of appendicitis of tubercular origin. The patient was a man, thirty-six years of age, both of whose parents had died of phthisis. He was first taken sick on August 4th with a chill, and severe headache and backache, and considerable epigastric pain. In the course of the next few days there were repeated slight chills, followed by fever and increased and more general abdominal tenderness. About two weeks later he developed an obstinate diarrhoea of a typhoid character. On September 12th, the morning temperature was 101° F., and the evening temperature 102° F., and the pain was more marked in the right inguinal and lumbar region. Appendicitis was thought of, but was excluded because

of the widely diffused tenderness. A diagnosis was made of typhoid fever. The diarrhœa resisted all medication, and on November 4th the patient died. At the autopsy the brain, heart, liver, and kidneys were found normal. Both lungs were studded with miliary tubercles, and the left lung contained an old cavity, and was very firmly adherent to the costal pleura at its apex. The spleen was twice the normal size, and contained many miliary tubercles. Tubercular ulcers were found in the lower portion of the ileum, and in the cæcum and ascending colon. The appendix was considerably swollen at its lower end, and contained about a drachm of dark-colored pus. Its anterior showed numerous miliary tubercles.

The question naturally arose—would the patient have been benefited if an early correct diagnosis had been made, and an operation performed?

Dr. Hodenpyl thought miliary tubercles were not infrequently found in the appendix, but he did not think this condition often gave rise to the symptoms ordinarily associated with what is called appendicitis. He could not see how an operation would have benefited the patient.

Dr. George P. Biggs thought it quite possible that there had been an appendicitis at some remote time without marked symptoms, and that subsequently there had been a deposit of tubercle. Quite recently he had seen a case of intestinal tuberculosis in which the appendix was enlarged and the mucous membrane ulcerated.

The President said that he had watched the progress of the case now under discussion, which was of interest clinically from the fact that the patient was supposed to have typhoid fever up to the sixth week of the illness.

#### CEREBRAL HEMORRHAGE.

DR. E. D. FISHER presented a brain removed from a man, sixty-one years of age, who was admitted to Bellevue Hospital on October 21, 1892. There was no distinct history of syphilis, and he had not been intemperate for many years. On October 16th, while driving, he suddenly lost control of the muscles of the left arm and hand. This was quickly followed by complete hemiplegia, facial paralysis, and loss of consciousness. When admitted to the hospital he was comatose, and the left side of the body was



cold. His pulse was 70, and full ; respirations 24, deep and stertorous ; temperature 95.8° F. It was not possible, owing to the condition of the patient, to say positively whether or not there was marked anæsthesia. For several days there was a low, muttering delirium, and finally distinct rigidity of the muscles of the back of the neck. Later on, he developed large bedsores ; the pulse became rapid and feeble, and the temperature rose ; and he finally died on October 30th. The speaker said that he at first made a diagnosis of thrombosis or slight hemorrhage, but as the symptoms increased, he concluded that there had been a renewal of the hemorrhage. The autopsy showed extensive œdema of the pia mater, covering the cortex and convolutions, and extensive arterial degeneration and calcareous deposits in the arteries of the base. There was a blood-clot about two inches in diameter involving the posterior portion of the internal capsule and lenticular nucleus, and extending to but not involving the optic thalamus. There was yellowish-brown softening of the surrounding parts. The heart and aorta were the seat of atheroma ; the lungs were emphysematous, and the kidneys cirrhotic.

Considering the size of the lesion, the symptoms corresponded very well with the situation of the clot. The speech was not so much impaired or the paralysis so extreme as in cases where the lesion is more anterior. It is just possible that there was first a thrombosis, and that the consequent softening deprived the diseased blood-vessels of their proper support, and led to the hemorrhage. The œdema is probably explained by the compression exerted by the blood clot, causing exudation of the watery elements of the blood.

DR. H. P. LOOMIS presented two brains taken from persons who before their death had complete paralysis with loss of sensation and motion on the left side. The first specimen was from a woman, thirty-six years of age, who died two hours after admission to the hospital. The lesion in this case was a pachymeningitis hemorrhagica interna. The second specimen was removed from a woman, forty-four years of age, who was well up to three days before her death. At this time she became suddenly paralyzed, and was partially comatose when brought to the hospital. On the following day she developed a typical Cheyne-Stokes respiration. The autopsy showed an internal hemorrhage which had destroyed the corpus striatum, internal capsule, and part of the optic thalamus.

*Stated Meeting, November 22, 1893.*

DR. H. P. LOOMIS, PRESIDENT.

CILIATED INFUSORIA FROM THE URETHRA.

DR. F. TILDEN BROWN exhibited some ciliated infusoria which he had found in the urine of a man suffering from pyelitis. When the patient first came to him he had hæmaturia and a cystitis. At the commencement of the treatment, examinations were made for gonococci and tubercle bacilli, and these showed the infusoria; hence, they were present at the time the patient came under treatment. It is probable that the free secretion of pus and the alkalinity of the urine rendered the urethra a suitable habitat for the infusoria, for they speedily die in normal urine; in fact, they seemed to thrive chiefly in physiological salt solution and in ordinary Croton water. He had, however, found them alive in this patient's urine as long as ten days after the urine was voided. At first he suspected that the infusoria came from the urinal, or from the bottle containing the urine, but he had had the patient pass some urine directly into sterilized flasks, and even then an examination made within one hour showed the presence of these infusoria. As they were not found in the urine drawn from the bladder by catheter, it would seem that they existed only in the urethra. There was no discharge from the meatus, but there was considerable muco-pus in the canal, and many shreds were found in the specimens of the urine containing the infusoria.

A CALCULUS CONTAINING TUBERCLE BACILLI.

DR. BROWN also presented a small calculus which he thought was probably of renal origin. The patient was known to have tubercular disease of the urinary tract. Specimens of urine were examined from time to time for tubercle bacilli, but none found. Finally, about two or three hundred minute, soft calculi were voided, and on crushing one of these and mounting it in blood-serum, the tubercle bacilli were found in large numbers. He had not before seen any mention of this. The composition of the calculus had not yet been determined, but it appeared to be phosphatic.

## RETENTION CYSTS OF THE KIDNEY DUE TO OCCLUSION OF THE URETER BY A CALCULUS.

DR. GEORGE C. FREEBORN presented a cystic kidney which had been found at a post-mortem examination. So far as could be learned, there had been no symptoms during life referable to this condition. The kidney was enormously enlarged, and was converted into a mass of thin-walled cysts, the walls of which were composed of fibrous tissue. Examination of various portions showed an entire absence of kidney tissue. The cysts contained a clear yellowish fluid, which was drawn off by a series of small punctures. The cysts were then filled with Flemming's fluid, and, after hardening, were preserved in alcohol. This original method of preparation had been described to the Society on a previous occasion.

## A CYST OF THE BROAD LIGAMENT.

DR. FREEBORN said that this specimen was removed by laparotomy from a married woman, twenty-three years of age, who was in the third month of pregnancy. The cyst contained 250 c.c. of perfectly limpid fluid. The operation was done on November 15th, and the patient had done exceedingly well, and had not aborted.

Dr. Byron said that this method of preparing cysts was far superior to any other with which he was familiar. He would look upon the cystic kidney as more probably of congenital origin, for when not congenital there are usually only one or two cysts.

Dr. Freeborn said that he had considered the specimen one of congenital origin until he found the large calculus which had occluded the ureter.

Dr. Brown asked if the method of preparing the cysts just described and recommended was applicable to specimens in which the contained fluid was quite thick.

Dr. Freeborn replied that he had been able to almost completely evacuate the celloid material of ovarian cystomata by using a large glass or metal canula. The chromic-acid solution was then injected through the same canula.

## PRESERVING THE NATURAL BLOOD-COLOR IN SPECIMENS.

DR. FREEBORN called attention to the fact that in the last specimen of cyst the color of the blood had been retained in the vessels. Many methods had been devised, and had proved un-

satisfactory. It had been found, however, that the blood coloring could be retained by first drying the specimen in the air for an hour or an hour and a half, and then immersing directly in *strong* alcohol. If put in fifty to sixty per cent. alcohol, the color will be destroyed. The same method can be used with solid organs, but as they cannot be so thoroughly dried as cysts the results are inferior.

#### CYSTS OF THE BRAIN.

DR. E. D. FISHER presented a brain removed from a patient, forty years of age, who died of exhaustion after a series of about sixty epileptic seizures, occurring within twenty-four hours. There was a history of imbecility associated with epileptic seizures, and marked hemiplegia with contractures on the hemiplegic side. Two large, well-defined cysts were found in the motor area of the left hemisphere of the brain, extending back into the occipital lobe, and the more posterior cyst was in communication with the lateral ventricle. The difference in the size of the two hemispheres was very apparent, but the opposite hemisphere of the cerebellum was not atrophied. It was not possible, of course, to decide so long after the occurrence of the lesion, whether the condition found in the specimen was the result of occlusion of a vessel, occurring *in utero* or shortly after birth, or whether it was due to hemorrhage. The specimen showed very clearly the futility of operating on such cases. He had ventured to operate on a similar case, where the man had a history of having had cerebral hemiplegia develop at the age of five years, and where it seemed possible that there might be a meningeal hemorrhage. Instead of this he found a cyst very similar to the one shown in this specimen. The cyst was drained, but the operation seemed to neither benefit nor hurt the patient.

#### THE LESIONS OF YELLOW FEVER.

DR. J. M. BYRON presented specimens from a man dying of yellow fever. While coming from Havana about three weeks ago he was taken ill on the steamer, and on reaching this harbor was put on one of the quarantine islands. When seen by the speaker he presented most of the symptoms of yellow fever—moderate yellow color, nausea, pain in the epigastrium, subsultus, and continued high temperature. The patient was twenty-four years of age, and his previous health had been apparently good.

The liver presented at autopsy the appearance more commonly seen in the early stage of the disease, when the degeneration of the liver cells is going on in the outer portion of the acini. The bladder, stomach, and intestines showed extensive hemorrhages. the kidneys were of special interest, because it had been recently claimed that cholera could be recognized by the lesions found here. The specimen presented a very similar appearance to that found in cholera, and the microscopical appearances were identical in the two diseases, even the collecting tubes being involved in the necrosis.

Specimens from cases of cholera and yellow fever were exhibited under the microscope.

Dr. Armstrong asked what was the condition of the heart.

Dr. Byron replied that it presented, along with the other organs, a condition of fatty degeneration.

Dr. Armstrong said he would lay more stress on this than on the appearance of the liver or kidneys, for they present no characteristic features; it is the association of the pathological condition in several organs rather than the appearance of any single organ, which justifies a diagnosis of yellow fever.

Dr. George Biggs asked if yellow fever could be positively differentiated at autopsy from a purpuric condition. He had recently made an autopsy on a case presenting quite similar lesions, yet the patient had been for a long time in the New York Hospital, and had presented the symptoms of acute purpura hemorrhagica without skin eruption. There was a distinct jaundiced condition and parenchymatous changes in the organs, with a few hemorrhages in the kidneys.

The President thought the parenchymatous changes would furnish the basis for a differential diagnosis.

Dr. Byron said that in yellow fever the clinical symptoms must be taken into consideration along with the results of the autopsy. In yellow fever there are very extensive hemorrhages of all the mucous membranes, while minute hemorrhages are very rare; in yellow fever there is fatty degeneration of almost all the parenchymatous organs, while in purpura hemorrhagica these changes were not nearly so extensive.

#### CULTURE MEDIUM FOR THE GONOCOCCUS.

DR. BYRON presented a culture-tube containing pure cultures of the gonococcus. Five years ago he had successfully cultivated

the gonococcus in this way on a medium composed of bouillon-agar containing two per cent. of cane sugar. One year after this, Bumm cultivated this germ on blood-serum, and, notwithstanding the assertion that it can only be cultivated on this serum, he had obtained much better results from the culture medium already described.

#### PRIMARY EPITHELIOMA OF THE FEMALE BREAST.

DR. E. HODENPYL presented a specimen of primary epithelioma of the breast, a condition so extremely rare that he had been unable to find a similar case on record. The patient was a widow, fifty-five years of age, who had been perfectly well up to four months ago, when, after a traumatism, a lump appeared in the breast. At this time it was about one inch in diameter, painless, and of slow growth; but about six weeks before her admission to the hospital it began to grow very rapidly, the skin became somewhat reddened, and there was a serous and sometimes a bloody discharge from the nipple. On admission, the tumor measured six inches in diameter and seven inches in depth; it was quite painful, the skin was reddened over it, and there was a slight serous discharge from the retracted nipple. The breast was removed by Dr. McBurney, who found at the operation that this tumor was really a cyst containing over one pint of fluid. The growth presented a cauliflower appearance, and on microscopical examination showed a typical structure of a squamous epithelioma, such as is found in the skin, and the same arrangement of the cells which is found in stratified epithelioma elsewhere. When stained, the specimen showed the "spine cells" very well. There was no evidence that the tumor sprang from the skin, and the only possible explanation seemed to be Connheim's theory of aberrant cells. Gross, in his text-book on *Tumors of the Breast*, speaks of epithelioma, but his description would seem to apply to adenoma rather than to true epithelioma.

#### ACUTE SEPSIS FOLLOWING CATHETERIZATION.

DR. GEORGE P. BIGGS said that the specimen presented was from a man, seventy-one years of age, whose previous personal history was absolutely negative. Last June he began to have some difficulty in micturition and the urine was occasionally tinged with blood. About three weeks before admission to the hospital,

after a hard day's work, he had retention of urine. A physician relieved him temporarily by catheterization, but after this there was distension of the bladder and painful micturition. Three days before coming to the hospital these symptoms were increased, and he was again catheterized. The following day he had headache and vomiting; the urine contained considerable blood, and the patient appeared stupid. On admission the prostate was found enlarged. A catheter was passed without much difficulty, and bloody and purulent urine drawn off. After evacuating the bladder there was still an area of dulness about six inches in breadth, extending up nearly to the umbilicus, and this led to the diagnosis of a probable tumor. There was moderate fever, the stupor increased, and he died in three days.

At the autopsy the fundus of the bladder was found to reach nearly to the umbilicus, and the entire anterior wall was firmly adherent to the parietal peritoneum; the omentum was adherent to the fundus of the bladder, and the neighboring coils of intestine were covered with a little lymph, but there was no general peritonitis. The bladder contained a large quantity of offensive ammoniacal urine; the mucous membrane was necrotic over a large area; there were numerous hemorrhages, and marked trabecular hypertrophy. The prostate was hypertrophied and nodular. The bladder walls were infiltrated throughout, and on stripping away the anterior wall from the peritoneum several pockets of pus were found. The ureters were moderately dilated and much congested; the pelves of the kidney were in a similar condition, and were filled with bloody and purulent urine. There was also double pulmonary thrombosis, which did not completely occlude the vessels. It probably occurred just before death, as it gave rise to no definite symptoms. The pus was stained, but only large numbers of staphylococci were found. There was evidently a very acute infection following the catheterization six days previous to death.

Dr. Armstrong asked if there were any arthritic symptoms in the case.

Dr. Biggs replied that there was no history of any.

Dr. Armstrong said that about six years ago he had under his care at the Marine Hospital a sailor who was supposed to be suffering from acute articular rheumatism. He developed endocarditis and died. The autopsy showed not only arthritis and endocarditis, but nephritis and cystitis, and subsequent inquiry elicited

the fact that he had some trouble with the bladder which had necessitated the introduction of an instrument. This had evidently caused infection. The lesions were very similar to those found in the case just reported

Dr. Byron recalled a case of cystitis similar to the one presented. The lesions resembled those produced by the virulent form of the bacillus coli commune, which seems to have a special necrotic action.

Dr. Hodenpyl remarked that in an article by Schmidt, just published, is a report of fourteen cases of cystitis due to this micro-organism.

#### CARCINOMA OF THE STOMACH ; ULCERATIVE ENTERO-COLITIS.

DR. GEORGE P. BIGGS then presented specimens taken from a woman, forty-one years of age, who, when admitted to the New York Hospital on October 19th, presented the symptoms of chronic gastritis. She was of intemperate habits, and since an attack of la grippe last February had had a constant cough with mucous expectoration. Since April there had been morning nausea and vomiting, and moderate emaciation. The physical examination of the chest was negative; the abdomen was distended; the epigastrium was slightly tender; the urine was normal. While in the hospital she had a very profuse diarrhoea. No hydrochloric acid was found in the vomited matter. A diagnosis had been made of carcinoma of the stomach, but this was afterwards thought to be erroneous. An acute peritonitis developed shortly before death, which occurred on November 20th. At the autopsy no gas was found in the peritoneal cavity, but there was a small amount of lymph and a large quantity of unusually watery—almost milky—fluid. About  $4\frac{1}{2}$  inches from the pylorus the wall of the stomach began to thicken, and at the pylorus it was 1 ctm. thick. At this point the submucous coat was three fourths of an inch thick, and rather soft. The mucous membrane showed papillary projections—the largest,  $1\frac{1}{2}$  ctm in diameter—projecting about three fourths of an inch above the surface. There were small nodular thickenings along nearly the entire greater curvature, and in some other places. The pylorus was narrowed to about  $1\frac{1}{2}$  ctm. in diameter, and the mucous membrane appeared to be superficially ulcerated. The duodenum presented nodular thickenings, and apparently superficial ulcerations. There was no new growth in the pancreas, nor were there



enlarged glands in the neighborhood of the stomach. The liver was rather large, and one section of the right lobe, an ovoid mass about two inches in diameter was found deeply embedded in it. It was firm and distinctly outlined, and presented the appearance of carcinomatous deposit. There were no other deposits in the liver. An examination of frozen sections from the stomach and liver showed these to be the seat of carcinoma, but it was rather strange that the mucous membrane was so slightly involved.

Extensive and peculiar lesions were found in the ileum. In the lower two feet of the ileum the mucous membrane was destroyed owing to the formation of numerous small round ulcers. The edges of these ulcers were undermined, and they appeared to have existed for some time. There were many similar ulcers in the large intestine, particularly in the descending colon. In the transverse colon were a number of pigmented points, which appeared to represent the healed ulcers of this type. None of these ulcers had perforated, but the peritonitis was probably the result of a direct extension of the inflammation from the deep ulcers. The spleen was of normal size; the mesenteric glands were slightly enlarged. Both lungs were the seat of extensive fibroid changes, apparently the result of the bronchitis originating in the attack of la grippe. Scrapings from the lungs and sections were examined microscopically but no evidence of tuberculosis discovered.

The President said he had seen at autopsy a similar thickening of the walls of the stomach. Sections were made of the thickened portions, which did not appear to be carcinomatous, yet on examination they showed, nevertheless, the existence of carcinomatous deposits.

D. J. S. Ely referred to a recent specimen in which there was regular and uniform thickening of the walls of the stomach, involving all except an area about two inches in diameter. This infiltration was about  $\frac{1}{2}$  ctm. in thickness, was carcinomatous, and began at the pylorus.

#### GIANT-CELL EPITHELIOMA OF THE NECK.

DR. BIGGS also presented a section of a tumor removed from a man, sixty-two years of age. Five years before, he sustained a compound fracture of the interior maxilla, and six months later a small tumor developed in the floor of the mouth. This was re-

moved at St. Luke's Hospital by Dr. Bull, nineteen months ago. It is said to have been a carcinoma. Subsequently a small nodule developed in the cicatrix and was removed by some other surgeon. Four months before admission to the New York Hospital, a small tumor was observed in the submaxillary fossa on the side where the fracture occurred. When removed by Dr. Bull it was found to be a distinctly encapsuled ovoid body, measuring 3 x 4 ctm. in diameter. It contained numerous areas of degeneration, and showed on microscopical examination the structure of epithelioma. The "pearls" were very numerous and characteristic. Some lymphatic-gland tissue was also found. A peculiar feature was the enormous number of giant cells, which resembled those found in giant-cell sarcoma and varied greatly in size. They appeared to be formed by the union of epithelial cells.

The specimen was referred to the Microscopical Committee.

#### A GLIO-SARCOMA OF THE BRAIN.

DR. FREDERICK PETERSON presented a specimen of tumor of the brain, taken from a man, fifty years of age. Up to five months ago he had had no symptoms except occasional dizziness. One morning last June he fell to the floor in a fainting attack. There was no paralysis and no symptoms of serious nervous disorder. He returned to business, but after two or three weeks began to feel weaker and to suffer from headaches. He gradually developed hemiparesis of the left side of the face, and of the left arm and leg, and the headaches and dizziness increased. When seen by the speaker three weeks ago, he had in addition left hemianopsia and double optic neuritis. A diagnosis was made of tumor of the internal capsule. The question of operation was broached by the attending physician, but it was not thought advisable owing to the absence of symptoms of irritation of the cortex. The specimen showed that the tumor did not affect the left side or any of the cranial nerves.

#### CEREBRAL THROMBOSIS ; A KIDNEY WITH TWO PELVES.

DR. J. S. ELY presented specimens taken from a woman, sixty-four years of age, who for the past ten years had had dyspnœa on slight exertion, accompanied by cardiac palpitation. Six years ago the left breast was amputated for carcinoma. Five years ago she suddenly become unconscious for about four hours, but there

was no aphasia or paralysis. One year ago she again became unconscious, this time only for a few minutes. On November 16th, she suddenly fell to the floor, and when found fifteen minutes later, the tongue deviated to the right, her voice was thick, there was partial paralysis of the left side of the face and of the left arm and leg. When admitted to Bellevue Hospital the following evening, the pupils were equal and responsive, the pulse full, regular, and slow, the cheeks flapping with expiration, and there was partial paralysis of the left side, but no loss of sensation. She was semi-conscious. On November 19th, the pupils were contracted and unequal and she was unconscious. She died early the next morning. The autopsy showed nothing abnormal about the dura mater or pia, but the right side of the brain was softer than the left, and the cerebro-spinal fluid was increased in quantity. There was extensive atheroma of the arteries at the base of the brain. In the right middle cerebral artery was a plug which completely occluded it. The softening was limited to the area supplied by this artery. There was no evidence of hemorrhage. The lungs were oedematous the heart was enlarged, and the aorta atheromatous.

The left kidney had two pelves, each one having its own ureter. The two ureters united about one inch from the bladder. The other kidney showed no such malformation. Both kidneys were the seat of advanced chronic diffuse nephritis.

#### PSEUDO-HERMAPHRODISM.

DR. ELY also exhibited a specimen from a male child, whose external genitals resembled those of a female. This appearance was due to a complete hypospadias, and a fusion of the scrotum, and to the fact that the testicles had not descended. This is the commonest form of so-called hermaphrodisism.

*Stated Meeting, December 13, 1893.*

DR. H. P. LOOMIS, PRESIDENT.

#### ENDOTHELIOMA OF THE TONSIL.

DR. WARREN COLEMAN presented, through the kindness of Dr. Asch, a specimen of endothelioma of the tonsil. Dr. Asch presented it before the Laryngological Section of the Academy of

Medicine on November 22d. The patient, a lady thirty-five years of age, consulted Dr. Asch on October 12th, because her dentist had told her on the preceding day that there was something wrong with her throat. She said that when the same dentist saw her two weeks before, there was nothing abnormal visible in the throat. Examination revealed a tumor of the right tonsil, completely filling the right half arch. It extended to the vomer in the middle line, and downward below the base of the tongue. It was flattened on the anterior surface, slightly nodular, red, and bleeding easily when touched. At one point it reached to the anterior pillar. There was no pain whatever, no interference with respiration or deglutition, and the patient had been up to this time absolutely unconscious of its presence. On the same side was an enlarged submaxillary gland, which was said to have been there since childhood. The growth was removed on October 14th with Knight's galvanic tonsillotome. On October 26th, a small outgrowth from the tonsil was noticed, which increased until November 15th, when it projected beyond the pillars internally, and well down the pharynx posteriorly. This was removed by a second operation.

The tumor, after hardening, measured 2.85 ctm. in its antero-posterior diameter, 1.56 ctm. in its vertical diameter, 6.35 mm. through the centre, and 9.5 mm. in its thickest portion. The free surface was irregular, and presented nodular elevations at different points. None of these nodules were large. Its attached portion was rough and ragged. Under a low power of the microscope, a vertical transverse section through the entire specimen showed the proper substance of the tonsil to be replaced by a tissue consisting of cells larger than lymph cells, and which contained a large number of blood-vessels. The remains of the tonsillar structure could be seen in places under the mucous membrane in the form of lymph nodules. The new tissue occupied almost the whole gland. In many parts of the section, the cells were arranged in distinct groups, which were only incompletely marked off from each other by small bands of connective tissue containing blood-vessels. The vessels were more numerous than in a normal gland, and were in intimate relation with the cells. Unfortunately, the tissue was immersed too long in weak alcohol, and, as a result, the protoplasm of the cells was largely broken down into granular detritus, but those which retained their protoplasm were seen to be irregularly oval, and of large size. The cells were distinctly of the flat variety, and

both cells and nuclei varied in size ; the latter generally showed karyo-kinetic figures, thus giving evidence of rapid subdivision. The section was stained particularly with a view to bringing out any fibres that might penetrate between the individual cells, but in no part of it could they be demonstrated.

The stratified epithelium covering the free surface of the tonsil showed signs of irritation in the vacuolation of the cells of the superficial layers, and the presence of small round cells infiltrating the lower layers (D'Arcy Power, *Brit. Med. Journ.*, Oct. 14, 1893). These latter were quite marked, and in places had extended far up into the epithelium.

The recurring portion of the growth presented essentially the same appearance, except that the cells were as a rule somewhat smaller. The section was almost completely surrounded by stratified epithelium, and under this a relatively large amount of lymphatic tissue remained. At the junction of the neoplasm with the lymphatic tissue, fibres could be seen between the cells, but they appeared to be the remains of the retiform tissue, disappearing as one passed into the substance of the neoplasm.

The malignancy of the growth was recognized immediately on examining the section, but its real nature was not apparent without close study. It had to be differentiated from carcinoma on the one hand, and from alveolar and lympho-sarcoma on the other. The size, shape, and characters of the cells, and their intimate relation with the blood-vessels distinguished it from carcinoma. It could not be an alveolar sarcoma, because the small amount of connective tissue which marked off the cell-groups did not send in prolongations between the individual cells, and because of the variety to which the cells belonged. Nor was it lympho-sarcoma, though it had its origin in a lymphatic gland, because of the absence of retiform tissue. The cells were held together by cement substance, the most careful examination having failed to demonstrate fibres between them.

Dr. Coleman said that the literature contained only a very limited number of reports of endotheliomata occurring in any part of the body, and not one in this region. According to the *American Text-book of Surgery* (page 200), when endotheliomata "arise in the pia mater, structurally and from their mode of origin many of them are alveolar sarcomata, whilst those originating in the pleura or peritoneum are carcinomatous, consisting of nests and clusters of epithelial cells presenting at their periphery

a columnar appearance, these cells being surrounded by a dense fibrous stroma." In Delafield and Prudden's book, it is stated that the cells making up an endothelioma may vary from the flat to the spherical variety. In the latter case it seemed to him that a diagnosis would be particularly difficult. Were it not for the special characters of the cells in this tumor of the tonsil, he would unhesitatingly class it as an alveolar sarcoma despite the absence of fibres between the cells. As before mentioned, the intimate relation of the blood-vessels to the cells excluded carcinoma.

#### INFANTILE CEREBRAL SPASTIC DIPLEGIA.

DR. FREDERICK PETERSON presented the fresh brain of a case of infantile cerebral spastic diplegia. The case was that of a female infant, aged twenty months, which had congenital diplegia, that is, spastic paralysis of all four extremities. He had frequently observed the child during his rounds at the Randall's Island institutions. It was subject to convulsions, had enormously exaggerated knee-jerks, ankle clonus, and the like, and its head was exceedingly small. The head measurements were: circumference, 32.5 ctm.; antero-posterior diameter, 11.5; greatest transverse diameter, 9.5; naso-occipital arc, 18; binauricular arc, 19. At the autopsy the skull bones were found to be considerably thickened, and all the sutures and fontanelles closed and united. The dura was very thick. There was an increased amount of subdural fluid. Over each hemisphere, as shown in the specimen, a large group of convolutions, including especially the motor area, was found wanting. The vacuum caused by this atrophy was filled partly by subdural fluid, and partly by the bulging of each ventricle, for there was also internal hydrocephalus. There was no communication between the ventricles and the exterior of the hemisphere, and the roofs were formed by a membranous sclerotic tissue. On microscopic examination of the spinal cord, degeneration and atrophy were found in the lateral column. The condition seemed undoubtedly to be due to a double meningeal hemorrhage, of which there was now no trace except the atrophied convolutions on both sides.

#### CHRONIC HYDROCEPHALUS WITHOUT A CEREBRUM.

DR. PETERSON then presented the skull and brain of a remarkable case of chronic hydrocephalus without a cerebrum. The

case was one of a female infant of eighteen months. Little could be learned of its early history. It had a large head with widely gaping fontanelles. The circumference of the head was 51.5 ctm. ; antero-posterior diameter, 18 ; greatest transverse diameter, 15 ; naso-occipital arc, 32 ; binauricular arc, 34. The child was blind, and had nystagmus. There was rigidity of all four extremities, occasional convulsions, and toward the last, opisthotonos. The child often cried out at night. It rested easier on either side than on the back. Speaking to or moving the child caused it to cry out. The circulation was poor ; the pulse rapid and feeble. The lungs were normal. The urine contained a slight trace of albumen ; there was no trouble with the bladder or rectal sphincters. The child could not nurse and was fed with a dropper. It died suddenly in a convulsion. The temperature never rose above 98° F. during its month's stay in the Infant's Hospital. Toward the last it vomited occasionally after feeding. At the autopsy 64 ounces of reddish serum were first removed by tapping through the anterior fontanelle. The skull was exceedingly thin ; the dura was thin ; the falx cerebri had disappeared ; at the base of the brain the basal ganglia stood out prominently, and the floors of the lateral ventricles were widely open. On removing the tentorium, the cerebrum was found to be of about the normal size. There was a mere vestige of each hemisphere, in a small part, some three inches long, at the base of each occipital lobe, lying on the floor of the skull. Microscopical examination showed degeneration and atrophy of lateral columns of the cord.

Dr. S. T. Armstrong said that the condition of the basal ganglia and of the remaining lobes of the brain suggested that this might have been a partial anencephalic monster rather than a case of hydrocephalus with absorption of so large a part of the brain, for such extensive absorption seemed almost incredible.

Dr. Peterson said that he had seen an illustration of another case of hydrocephalus in which there had been almost as much wasting as in the specimen just presented. The fact that it was not a lack of development was proven by an examination of the spinal cord, which showed descending degeneration of the pyramidal tracts. If the case had been one of arrest of development, one would probably not find any trace of the pyramidal tracts.

Dr. Armstrong asked if this would not be a violation of the

law that lesions of the cortex have no effect on producing lesions of the peripheral nerves ; in other words, were it not a fact that the evolution of the pyramidal tract was independent of the cortex.

Dr. Peterson replied that any lesion of any part of the motor fibres would result in degeneration toward the periphery.

Dr. Coleman said he had seen quite often a condition similar to that shown in the specimen, in dogs, monkeys, and pigeons, where a portion of the brain had been purposely injured or removed in experiments. Almost an entire cerebral hemisphere had been absorbed in these instances, leaving only a large sac filled with fluid.

Dr. Peterson said that the most remarkable feature connected with this case was that the child was reported to have had convulsions. If this were true, it is very remarkable, because it was now believed that convulsions do not occur except from some cortical disturbance.

#### EXTENSIVE CYSTOID DEGENERATION IN THE ADULT KIDNEY.

THE PRESIDENT presented two kidneys showing extensive cystic degeneration occurring in the adult. Although this condition was quite common in children, in his experience, it was rare in adult life. The patient was forty-three years of age, and was admitted to the alcoholic wards of Bellevue Hospital, suffering from acute alcoholism. He improved for a few days, and then became so lethargic that he was aroused with difficulty. He gradually grew weaker, and finally became comatose, and died in this condition on the twentieth day after admission. Only a chemical examination of the urine was made ; this showed a small quantity of albumen, and a specific gravity of 1014. The autopsy was made thirty-two hours after death. Physical development was excellent ; the brain, heart, lungs, and spleen were normal ; the liver was slightly enlarged and fatty. Both kidneys were enlarged, and weighed nine ounces each. The whole surface of both kidneys was studded with small cysts, varying in size from a pea to a cherry. Similar cysts were found throughout the substance of the organ. Microscopical examination of the fluid contents of the cysts showed crystals of uric acid, blood corpuscles, granular matter, and some articular crystals of undetermined composition. The cysts were lined with flat cells. The kidney elsewhere between the cysts showed quite extensive chronic parenchymatous



nephritis; hence, the condition of the kidneys in the absence of other causes must be looked upon as responsible for the death.

The speaker was of the opinion that adults with cystic kidneys usually died of intercurrent renal disease, the symptoms ordinarily being those of Bright's disease. He was not aware that the condition was never diagnosticated during life. Two explanations had been given for this pathological condition: one, that it was an excessive development of the small microscopical cysts seen in the kidney, in the cirrhotic kidney; the other, offered by Virchow, that these cysts represent the low degree of the foetal cystic kidney.

The speaker said that cysts of the kidney were divided into: (1) foetal cystic kidneys; (2) kidneys containing one or two cysts, and having no pathological significance; (3) the cysts found in the small cirrhotic kidney; and (4) extensive cystic degeneration in the adult.

#### ABSCESS OF THE LIVER.

DR. E. K. DUNHAM presented some specimens for DR. MCALPIN.

The first were from a man twenty-three years of age, of rather intemperate habits, whose last illness extended from October 9th to December 4th. Physical examination showed consolidation of the lung with some exudation into the right pleural cavity, which was diagnosticated as empyema. About half a pint of purulent matter was withdrawn by the aspirator. The patient died a few days later. At the autopsy, it was found that the liver was the seat of two or three large abscess cavities. The upper surface was adherent to the lower surface of the diaphragm and there were adhesions between the upper surface of the diaphragm and the right lung. The lung appeared to be the seat of a lobular pneumonia, and it appeared also as though the aspirating needle had penetrated the liver, and that the pus was withdrawn from here. Bacteriological examination of the pus taken from the liver at autopsy revealed the presence of a variety of micro-organisms, chiefly the colon bacillus and the streptococcus.

#### AMOEBOID DYSENTERY.

The other specimens were taken from a patient who was ill only about four days. The temperature was 104° F., the pulse

and respiration rapid, and these were associated with abdominal pains and bloody stools. The case was treated for typhoid fever. At the autopsy the colon was found to be the seat of dysenteric ulceration; the liver contained a number of abscess cavities, and the pus in these was rather thick. Bacteriological examination of the pus from an unopened abscess failed to reveal micro-organisms, but microscopical examination of the colon showed bodies of proper dimensions, and containing vacuoles and indistinct nuclei, thus corresponding in appearance to the *amœba coli*. The amount of suppuration was quite remarkable considering the short duration of the disease.

Dr. Armstrong remarked that studies at the Johns Hopkins University would lead us to believe that amœboid abscesses of the liver from the transmigration of the *amœba coli* were more frequent than was usually supposed.

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*Stated Meeting, December 27, 1893.*

DR. H. P. LOOMIS, PRESIDENT.

MICROCEPHALIC IDIOCY WITH EPILEPSY AND BLINDNESS.

DR. FREDERICK PETERSON presented the fresh brain from a case of this kind. The patient was a female, twenty-eight years of age, and was from birth an idiot, with epilepsy and some left hemiplegia, belonging therefore to the class of congenital spastic hemiplegias. She averaged one epileptic attack daily until three days before death when she went into the *status epilepticus* and had seizures about every four minutes, general in character, though sometimes left-sided. Though she could distinguish light she could not find her way about, and had all her life to be cared for like a child. At the autopsy, the skull was found to be microcephalic to some degree. The bones were thickened and the sutures closely united. The dura was normal, as was also the pia. Both occipital lobes were the seat of great atrophy and sclerosis, the loss of tissue being made up for by widely dilated posterior horns in the ventricles. The cerebellum projected far beyond the posterior lobes; the anterior lobes were small and narrow, and the atrophy and sclerosis extended partly into the motor area on the right side.

## EXTENSIVE TYPHOID ULCERATION.

DR. GEORGE P. BIGGS presented the intestine from a case of typhoid fever. It was interesting on account of the extensive lesions of the cæcum and ascending colon. The case presented the ordinary clinical history of typhoid fever and had progressed to the fourth week, the temperature remaining quite high most of the time. She did quite well up to about twenty-four hours before death, when she complained of abdominal distension and pain. The autopsy showed acute general peritonitis of short duration. There were the usual lesions of typhoid fever in the spleen and mesenteric glands, and also in the lower three feet of the small intestine, but from the cæcum up nearly to the hepatic flexure of the ascending colon the ulcers were very large and deep, and were so numerous that almost half of the mucous membrane had been destroyed. The ulcer which caused the peritonitis was located in the anterior wall of the cæcum at about the level of the ileo-cæcal valve. Here the ulceration had extended down to the peritoneum. Perforation had not occurred, but on lifting the intestine, the slight additional pressure brought to bear on this point was sufficient to cause rupture.

The speaker said that the ulcers in the large intestine in cases of typhoid fever were quite common, in fact it had been his experience that an entire absence of them here was the exception rather than the rule. In this case all of the large intestine was involved, one ulcer being found as low down as the rectum, but the ulcers beyond the ascending colon were few.

Dr. S. T. Armstrong said it had not been his experience that ulcers of the colon were frequent in typhoid fever, or that the ulceration was so extensive as in this specimen. He thought it possible that this might have been a case of ulcerative ileo-colitis, in which case the symptoms would probably closely resemble those of typhoid fever.

The President said he would consider the ulcers in the specimen to be characteristic of typhoid fever; the size, the floor of the ulcer, and the clean-cut edges should distinguish the typhoid ulcer from the ragged-edged dysenteric ulcer.

Dr. F. Tilden Brown said that about ten days ago at the Presbyterian Hospital he had been present at an autopsy on a case of typhoid fever, and there was even more extensive ulceration, very large ulcers being found in the upper part of the rectum. The patient had had several severe hemorrhages, and although a

number of the ulcers were exceedingly deep there had been no perforation.

Dr. Biggs said that in the cases of ileo-colitis which he could recall the mucous membrane as a whole showed inflammatory change, and there were comparatively few ulcers of Peyer's patches and of the solitary follicles. He had noticed these ulcers of the colon especially in the cases of typhoid fever which he had seen this year.

Dr. Armstrong said that in the course of his reading he had seen it stated somewhere that cases of typhoid fever treated by cold baths exhibited usually extensive ulceration. He would therefore like to know whether this accorded with the experience of Dr. Biggs.

Dr. Biggs replied that most of the cases he had seen had had the cold-bath treatment; but he had never before had his attention called to the fact that in such cases the ulceration was more extensive.

Dr. BIGGS then presented a

#### CYSTIC CHYLANGIOMA.

The specimen was an abdominal tumor removed from a girl of seven years, who had been suffering with symptoms of intestinal obstruction for eighteen days. The tumor was a lobulated cystic mass measuring 9 x 6 x 3 ctm. One surface was covered by normal peritoneum, while the other was roughened and showed the lines of incision made in its removal. The cyst cavities communicated more or less freely with each other, and were partially collapsed, as the result of aspiration of the largest one and the cutting of many small ones during the excision of the tumor. They varied in size from pin-points to the largest which were 5 centimetres in diameter, and were held together by adipose tissue. In the natural state, before aspiration, the tumor must have been nearly three times its present size.

Microscopical examination of the whitish fluid from the cysts showed only a few leucocytes and much granular matter. Sections of the more solid portions of the tumor showed irregular spaces, probably dilated chyle vessels, containing granular matter, and more or less completely lined with elongated, flattened cells. Between these spaces was adipose tissue, a few areas of small round cells, and a few small lymphatic glands. The tumor, therefore, was a "cystic chyliangioma, probably congenital in origin,

which did not cause symptoms until it had obtained sufficient size to produce intestinal obstruction.

The speaker said he was indebted to Dr. O. O. Cooper, of Hinton, West Virginia, for the specimen, which was accompanied by the following history :

Two years previous to her last sickness the child had an attack of severe pain all over the abdomen, with vomiting and intestinal obstruction, lasting four or five days. After this she would often stop suddenly, while playing, and complain of severe abdominal pain. When Dr. Cooper was called in consultation he learned that she had suffered constant severe abdominal pain for eighteen days, during which time nothing had been passed by rectum, and the stomach had refused to retain food, the vomited matter being faecal on several occasions. Life had been maintained by the use of nutritive enemata. She was extremely emaciated, had an anxious expression, and her abdomen was so tender it could not be touched. Her temperature was normal, pulse 110 and very feeble. She absolutely refused to take nourishment by mouth because of the vomiting which was sure to follow.

Operation was strongly advised as holding out the only possible chance of recovery, intussusception of volvulus being suspected. Upon opening the abdomen the whole intestinal tract was found much congested, almost of a mahogany color. An irregular, lobulated, cream-colored tumor, nearly as large as a child's head, was found attached to the lower end of the ileum for eight inches. It looked like fat, but was elastic and fluctuating. A trocar was introduced into the largest lobe, and about five ounces of chylous-looking fluid escaped, leaving the whole mass flabby. Some hesitation was felt about undertaking the removal of the tumor, but as it was rather easily stripped from the gut, excision was finally decided upon. Many ligatures were used, and the wound was packed with gauze. During the operation the patient passed a quart or more of faeces. She rallied well, said she felt better than she had in weeks, and took and retained milk and whiskey by mouth. The improvement was only temporary, however, and she died the following day. No autopsy was obtained.

A few of these chylous tumors of the intestinal canal, originating in the mesentery, as in this case, have been described ; they are made up of enormously dilated chyle vessels. They are of congenital origin, but as they grow they give rise to symptoms usually earlier than in this case.

*Anniversary Meeting, January 10, 1894.*

DR. H. P. LOOMIS, PRESIDENT.

## A STAINING METHOD.

DR. J. M. BYRON described an improved method of staining, which he said was based on the action of aniline colors on the protoplasm and the histone of cells. The fluid consisted of equal parts of Ehrlich's acid hæmatoxylin, a saturated solution of orange, and a saturated solution of rubin S., or, as it was more commonly called, acid fuchsin. The specimen after being taken out of any solution—no matter what—was immersed in this staining fluid for a few minutes—the exact time must be determined by experience. After the sections had been deeply stained they were transferred to a decolorizing solution consisting of one part of alcoholic solution of picric acid and two parts of distilled water. After a few seconds the sections were transferred to absolute alcohol, then to the clearing agent (any of the essential oils usually employed), and finally into balsams. The method was not new in principle, but it seemed to possess more than the usual selective action on protoplasm and on different kinds of cells. Connective tissue was stained by it a permanent and very bright red. It was useful in distinguishing between a spindle-cell sarcoma and a myoma, for the cells of the muscular tissue were stained a dark yellow, the connective tissue red, and the spindle cells of sarcoma of a brownish tinge with blue nuclei. The stain appeared to be permanent.

## CARDIAC DILATATION ; PULMONARY THROMBOSIS.

DR. GEORGE P. BIGGS presented a heart showing great dilatation and very little hypertrophy ; the wall of the left ventricle appeared much thinner than normal, the valves were all normal, and their orifices were of normal size except the tricuspid which readily admitted four fingers. The right lung was also presented, as it contained three large infarctions, the largest of which had a diameter of 7 cm. and was located in the upper part of the lower lobe. The two others were about the size of walnuts, and were situated a little lower. There were no infarctions in the upper lobe. There was one infarction in the lower and posterior part of the lower lobe of the opposite lung, which measured 5 cm. in

diameter. The vessels leading to these infarcted areas were occluded by thrombi, all of which were whitish or grayish in color, firmly adherent to the vessel wall, and not broken down.

The specimens were removed from a man, forty years of age, a patient at the New York Hospital. He stated that two weeks before his admission he first noticed swelling of his legs, and that it was brought on by exposure to cold. Five days later he noticed for the first time blood expectoration with marked dyspnoea, headache, and some thoracic pain. His principal complaint was the cough and severe dyspnoea. On admission he had a temperature of 101° F., respirations were 38, and pulse 124. He was quite cyanotic, had slight general anasarca, and over the right chest posteriorly in the lower part was marked dulness with broncho-vesicular breathing and voice, and many fine moist râles. Over the lower part of the left lobe were numerous fine moist râles. Fluid was also discovered in the right pleural cavity. The cardiac area seemed to be increased, and the apex beat was most distinct three and a half inches to the left of the median line in the fifth space. The heart sounds were feeble, and there were no murmurs. The temperature continued to be elevated, all the symptoms increased in severity, and he died three days after admission. At the autopsy, in addition to the lesions already presented, there was marked chronic congestion of the kidneys, liver, and spleen, the heart was much distended with post-mortem clots—some of them thoroughly decolorized, but none ante-mortem. The main pulmonary artery was free from thrombi, and the aorta appeared to be in an unusually healthy condition. One branch of the coronary artery contained a small area of atheroma, but was otherwise normal. A careful examination was made of the venæ cavæ and the iliacs, but no thrombi were found. It appeared to be a case of primary pulmonary thrombosis at several points, producing the infarctions mentioned. The right pleural cavity contained 1800 c. c. of sero-fibrinous fluid, and there was considerable fibrin on the surface of the pleura. There were some recent adhesions, and some older adhesions posteriorly. A teased specimen of the heart muscle showed under the microscope considerable granular and fatty change in the muscular fibre. This seemed to be the only explanation of the great dilatation. At the autopsy, the question arose as to whether the pleuritis antedated the thrombi, and as to the relation of the cardiac dilatation to the conditions present. It seemed to the speaker that the cardiac dilatation had

existed for some time, as indicated by the changes in the spleen and kidneys. Coincident with the development of œdema of the limbs (seventeen days before death), the patient probably contracted, as a result of exposure, pleuritis of a rather subacute type, which gave rise to no decided symptoms for nearly two weeks. By this time the fluid had become sufficient in amount to cause considerable compression of the lung, and this by still further embarrassing an already enfeebled circulation, was the immediate cause of the thrombosis. With the formation of the infarctions marked dyspnoea and bloody expectoration developed. The man was a clerk by occupation. None of the organs except the heart contained any apparent excess of fat.

DR. BYRON said that from the history and the pathological changes in the lung he would be inclined to think there had been an acute dilatation of the heart. It was a disease not often found in this country, but more common in countries where young military recruits were required to make forced marches. There seemed to him also to be more than a simple infarction of the lung; he thought there was some pneumonia. From the high temperature and the post-mortem appearances it would seem that there was a multiple pneumonia besides the infarctions. If there had been no inflammation around the vein, he could not understand how these multiple thrombi could originate.

Dr. Briggs said that when quite fresh the appearance of the specimen was not so much like that of pneumonia. The temperature during the man's last illness was only 100° to 101.5° F. In one other case, seen recently, in at least six points there were small thrombi which did not occlude the whole vessel. He saw no reason why they should not form as well in the lung as in the heart, where they were well known to be the result of a weakened circulation. The explanation given of the dilatation of the heart seemed to him quite plausible.

Dr. Le Boutillier asked if the veins of the legs had been examined, for a portion of thrombus might have been detached from here.

Dr. Briggs replied that he had examined along the iliacs and down to the femorals, and had felt along these vessels.

Dr. T. M. Prudden said that one of the most interesting and obscure of the pathological lesions met with rather rarely was thrombosis of the pulmonary vessels. He had seen several such cases, and in none of them had there appeared to be a lesion of



the vessel wall which would account for the formation of thrombus, yet unquestionably such a lesion was present. The thrombi had been usually single, although he had met with multiple thrombi in two or three instances. The condition of the heart in this case would, it seemed to him, account for the thrombosis. The whole subject of pulmonary thrombosis required thorough study. In a considerable proportion of the cases he had seen the thrombosis had occurred after a safe and uneventful delivery.

On motion, Dr. Biggs was requested to report the results of his further study of the specimen.\*

#### EXTREME PULMONARY EMPHYSEMA.

DR. H. S. STEARNS presented a specimen of extreme emphysema of the right lung. When the sternum was removed at the autopsy, the right lung bulged out several inches beyond the chest wall, and also over to the left side. The left lung was firmly bound down to the chest wall posteriorly, and was thickly covered with new fibrous formation. It was impossible to separate the heart from the pericardium, the left lung and heart being bound down together to the chest wall. The capsules of the spleen, liver, and both kidneys were greatly thickened.

The subject from whom this specimen was taken was a woman about seventy years of age, an inmate of the almshouse, who was supposed to be an ordinary case of phthisis. A few days ago she fell and struck her head, and remained unconscious to the time of her death.

The President said that he saw the specimen when fresh, and he had never observed before such extreme emphysema. The sudden death could be explained by the heart being crippled by adhesions and by the dilatation of its cavities.

#### A CAUDAL APPENDAGE.

DR. HALSTED MYERS presented a tail-like appendage about 1½ inches long, which he had removed from a baby girl. The structure was of fibrous tissue and fat; there were few blood-vessels, and no excess of nerve tissue, judging from the lack of sensitiveness. The coccyx made a right-angle with the sacrum,

\* See proceedings of meeting, February 6, 1894.

projecting to the right side. The tail was attached to the tip of the coccyx. The vagina was in the median plane of the body, but the rectum was about  $1\frac{1}{2}$  inches to the right of this, near the end of the coccyx, in a deep supernumerary transverse gluteal fold.

Dr. Byron said that this specimen reminded him of a remarkable case of the kind which he saw some years ago, in which a man had a caudal appendage about eleven inches long. It was a continuation of the coccyx. The case was published at the time, and attracted considerable attention from the fact that there was only one other similar case on record—one observed by Nelaton.

#### THE BRAIN IN GENERAL PARESIS.

DR. E. D. FISHER presented a brain from a case of general paresis. It was removed from a man fifty-six years of age, a machinist by occupation, who was admitted to the Ward's Island Hospital, February 9, 1893. There was a history of intemperance, but none of syphilis. He had the usual delusions of grandeur in regard to wealth, and exhibited marked tremor in the face and tongue and hands. He finally passed into a state of dementia, and died a few days ago. The progress of the disease was quite rapid, its duration being only six months. There was a fairly well marked meningitis involving the pia, and adhesions of the dura and the pia, especially over the frontal lobes, where calcareous deposits could be felt. There was not much pachymeningitis. The appearance of the brain would seem to indicate an encephalitis also. The pial inflammation was more marked on the base of the brain. The arteries were the seat of atheromatous changes. Nothing abnormal was observed in the ventricles, but no microscopical examination had yet been made. The specimen represented the early stage of general paresis, where there was a simple meningitis or meningo-encephalitis. In extreme cases there was considerable pachymeningitis and sometimes meningeal hemorrhage, thus explaining the epileptic and the paralytic seizures. The age of the patient was fifty-six years, and his intemperate habits would account for the atheroma. General paresis could be said to be the only mental disease where definite lesions were invariably found. Although there had been some symptoms of tabes, he did not expect to find, on examina-

tion of the cord, either the posterior or the lateral columns affected.

Dr. Ira Van Gieson said that tabes began in several different ways—sometimes in the spinal cord, sometimes in the roots. He did not think we could say that cases of general paresis behaved differently from uncomplicated tabes. It might be a disease of the cord itself, or outside of the cord, and the disease in the cord be secondary to it. It was rare to find a pure case of tabes which had passed into general paresis, or, on the other hand, a case of general paresis with well defined symptoms or signs of locomotor ataxia.

Dr. Fisher said that in many of these cases where there was apparently exaggerated reflexes and ataxia, the post-mortem changes were very slight. In the cases of locomotor ataxia he had seen, he could not recall one which had ever passed into general paresis, although he was aware that such cases had been reported.

#### GUANIN GOUT IN THE HOG.

DR. JAMES EWING presented a specimen of this kind which had been recently sent to the laboratory of the College of Physicians and Surgeons for examination. The condition was not infrequently mistaken for trichinosis. The deposits in the piece of ham exhibited by the speaker were of a light color, and instead of being spherical, as in trichinosis, radiated into the muscular fibres. In its composition, guanin was a product of nitrogenous metabolism very similar to uric acid, but less highly oxidized. It was found in the tissues in combination with carbonic acid or some organic acid, for when treated with sulphuric acid, it effervesced, which pure guanin did not do. The deposits in the ham did not crystallize in the same form as pure guanin, but this process was modified by its combination with a colloid, probably a degenerated form of muscular tissue. As the specimen in this instance had been cooked before being submitted to examination, no further investigation could be carried on. About four other cases had been reported. It was first noticed by Virchow in 1856; then another German reported one case in 1868, and in 1888 Dr. Walter Mendelson, of this Society, received for examination an entire ham which was affected in this way. His report of the case appeared in the August number of the *American Journal of the Medical Sciences* for 1888, and contained references to the literature of the subject.

## A DEODORIZING AND PRESERVATIVE FLUID.

DR. EWING also spoke of the manner in which this specimen had been preserved. It had been found when a tissue was placed in a jar on cotton saturated with a forty-per-cent. solution of "formaline" or formic aldehyde, decomposition was arrested and the odor destroyed.

Dr. George Biggs said that about one year ago the late Dr. Vought presented a similar specimen to one of the societies in this city. It was at first thought to be a specimen of trichinosis. In that case the nodules were not as large as those seen in the specimen just presented.

DR. J. S. ELY presented a specimen of

CARCINOMA OF DUODENUM COMPRESSING COMMON BILE-DUCT;  
OBSTRUCTIVE JAUNDICE; RUPTURE OF DILATED GALL-DUCTS  
WITH RESULTANT PERINEPHRITIC BILIARY CYST.

Some of those present may remember a rather remarkable case of primary carcinoma of the common bile-duct which it was my good fortune to be able to present to this Society in March, 1889. The case was noteworthy in that the only carcinomatous deposit in the body was a small tumor, 11 x 9 mm., situated at the opening of the common bile-duct into the duodenum. Pressure upon the bile-duct caused obstructive jaundice, for which Dr. Hartley undertook cholecystotomy, the patient dying later of secondary hemorrhage. It was evident that the accident of the operation had enabled us to see a carcinoma which had undoubtedly developed from the common bile-duct, in a very early stage and before the occurrence of secondary tumors, which might have thrown some doubt upon the actual point of origin of the tumor. A search through the literature at that time yielded only seven cases of a similar nature. It is consequently not a little remarkable that I should be able to show you this evening some specimens from a case which is its almost exact counterpart.

The patient, M. P., aged forty-one, a native of Ireland, and a varnisher by occupation, was admitted to Bellevue Hospital on September 15, 1893. His mother is said to have died of cancer.

In June, 1893, while at work, he was suddenly taken sick with diarrhoea and vomiting of blood (about  $\frac{1}{2}$  pint). The next day he again vomited, but this time the vomitus was dark-colored,

"like bits of liver" as he described it. He had also slight occasional pain over the liver during the first three days of his illness. In about a week he noticed that he was getting jaundiced, and from that time it has never left him, but has pretty steadily increased in intensity. He had lost about fifteen pounds in weight up to the time of his entrance into the hospital. The bowels moved regularly, but the stools were white and pasty. Appetite remained good. Itching of the skin, biliary coloration of the urine, and the depressed mental condition so frequently observed as concomitants of intense jaundice were noticeable features of his case.

On admission to the hospital physical examination disclosed nothing but intense jaundice, uniform enlargement of the liver (lower border 3 inches below full border of ribs), dilatation of the gall-bladder, and some increase of splenic dulness. There was no fever. Little change took place in the patient's general condition until December 25th, when he was again seized with vomiting, which, on the 27th, culminated in his vomiting a considerable quantity of thin blood, after which he was much prostrated. On the 28th, clots of dark blood and fresh blood were vomited, and the patient was infused, but died on the following day of exhaustion.

At the autopsy, which was performed by Dr. Waring, House Physician of the First Medical Division, the liver was found to be much enlarged and deeply stained with bile. The gall-bladder and biliary ducts were greatly dilated; the gall-bladder to the size of a small orange, the common bile-duct to a lumen  $1\frac{1}{4}$  cm. in diameter. The dilated bile-duct protruded into the lumen of the duodenum to a distance of about a centimetre in the form of a large papilla. Just below this, in the wall of the duodenum apparently, was a hard circumscribed mass, about the size of a small pea, which completely closed the mouth of the bile-duct, and evidently formed the obstruction which gave rise to the jaundice. In removing the left kidney, it was found to be enclosed in an irregular cavity containing about a pint of thin, greenish liquid. On further dissection this cavity was found to extend upward behind the spleen and stomach to the posterior portion of the left lateral ligament of the liver, the layers of which were separated, and the cavity was traced to the edge of the left lobe of the liver, where it was found to be continuous with the ruptured extremity of a dilated gall-duct. This sac lay entirely

behind the peritoneum, and the surrounding tissue showed only a slight degree of inflammatory reaction. There was no peritonitis.

The stomach in places was much congested ; there was no ulceration.

The mucous membrane of the duodenum appeared normal.

The pancreas was normal ; no dilatation of its duct was discoverable. The spleen was slightly enlarged, and showed a moderate degree of chronic interstitial splenitis.

The kidneys were of about normal size, capsule of each was somewhat adherent, its surface granular, cortex thin, markings indistinct. The left kidney, in addition, contained a small cyst.

The heart and lungs were normal.

All the organs were deeply stained with bile pigment.

*Microscopical examination* of the small mass in the wall of the duodenum which caused the obstruction shows it to be scirrhus sarcoma. Small alveoli, filled with irregularly shaped cells, are scattered through a dense fibrous stroma.

The case is one of carcinoma at the mouth of the common bile-duct, with obstructive jaundice, great dilatation of the biliary passages, and consequent rupture of one or more of those on the surface of the liver, giving rise to a large perinephritic biliary cyst.

The specimen which is passing consists of a portion of the left lobe of the liver, the gall-ducts of which have been injected by Dr. Roosevelt with a blue mass. At a point on its edge which represents the posterior edge of the left lobe the layers of the lateral ligament may be seen separated and the blue injection mass emerging from a gall-duct through a rupture in its wall and entering the cavity of the retroperitoneal cyst, thus affording indisputable proof of the origin of the cyst from the rupture of a gall-duct.

As the result of a very hasty consultation of the literature of obstructive jaundice I have been unable to find record of any case of rupture of a gall-duct. Orth, however, mentions rupture as a rare consequence of traumatism in extreme dilatation of the gall-ducts, and he states that this accident is quickly followed by death as the result of acute peritonitis. From this it would be inferred that he was not acquainted with extraperitoneal rupture, such as occurred in the case just reported.

Dr. George P. Biggs said that a specimen showing rupture of the bile ducts had been presented to the Society about two years

ago by Dr. Herman M. Biggs. The rupture had occurred in the left lobe of the liver from excessive dilatation resulting from a gall-stone obstructing the common duct. The case occurred at the almshouse, and had been seen by him during life. There was a large tumor in the left side of the abdomen from which large quantities of biliary fluid were removed by aspiration on two or three occasions. It was found that a cavity had been formed, the posterior wall being composed of matted coils of small intestine, and the anterior wall by the parietal peritoneum.

The speaker also called attention to a case of primary carcinoma of the papilla of the gall-bladder very recently reported by Dr. R. F. Weir. He had made the autopsy on this case at the New York Hospital, and had found a small primary adeno-carcinoma which obstructed both the common and the pancreatic duct. No metastasis had occurred.

Dr. Ely said that at the time he searched the literature and found the seven cases, he excluded every case in which there was any secondary nodule anywhere else in the body, simply to rule out any possibility of error. He wished to emphasize the fact that the carcinoma did begin in the common bile-duct or in the gall-ducts. There were a good many cases where the gall ducts would seem to be the primary seat of the carcinoma, but the existence of other nodules of carcinoma made this rather doubtful. In his case, as well as in that of Dr. Biggs, the rupture occurred in the left lobe of the liver. In Wickham Legg's book on jaundice it was stated that in cases where there was such extreme dilatation of the gall ducts as to lead to the formation of cysts on the liver, and even in less severe cases, he had noticed the greatest dilatation in the left lobe of the liver, but he was unable to explain it.

Dr. W. B. COLEY presented a specimen of

#### CARCINOMA OF THE CLAVICLE.

It was taken from a woman who was in the New York Cancer Hospital last August. In 1886 she was operated upon at the hospital by Dr. Clement Cleveland for a tumor diagnosed as a cystic tumor of the breast. This was soon after the opening of the hospital, and apparently no microscopical examination had been made. She left the hospital in four weeks, but returned in one year with a tumor in the same locality, and also enlarged

axillary glands. These were removed, and she remained free from the disease for three years. One and a half years ago she noticed a small swelling at the inner end of the right clavicle, which grew slowly. She was admitted to the Presbyterian Hospital with this last July. There were no tumors elsewhere. She was supposed to have sarcoma of the clavicle, and was sent to the Cancer Hospital to the speaker to receive inoculations of the toxic principles of erysipelas. A few injections were given pending the report of the microscopical examination. As this showed the growth to be a typical carcinoma, and as she apparently had internal complications, the treatment was discontinued. The tumor had, however, been reduced seven eighths of an inch in circumference. The autopsy showed the entire inner end of the clavicle occupied by this tumor which apparently started in the central portion of the bone, and which was attached to the first rib. The upper lobe of the right lung was also involved, and the entire liver was filled with an enormous number of carcinomatous nodules. The case was exceedingly interesting, because carcinoma of the clavicle was rather rare, and also because the interval between the last operation and the recurrence was about three years.

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The following officers were elected for the year 1894 :

*President.*—GEORGE C. FREEBORN.

*Vice-President.*—R. H. SAYRE.

*Secretary.*—O. C. LUDLOW.

*Treasurer.*—JOHN H. HINTON.

*Editor.*—JOHN S. ELY.

*Committee on Admissions and Ethics.*—GEORGE P. BIGGS, H. S. STEARNS, JOHN S. ELY, W. T. ARMSTRONG, R. G. FREEMAN.

*Committee on Publication.*—T. M. PRUDDEN, WARREN COLEMAN.

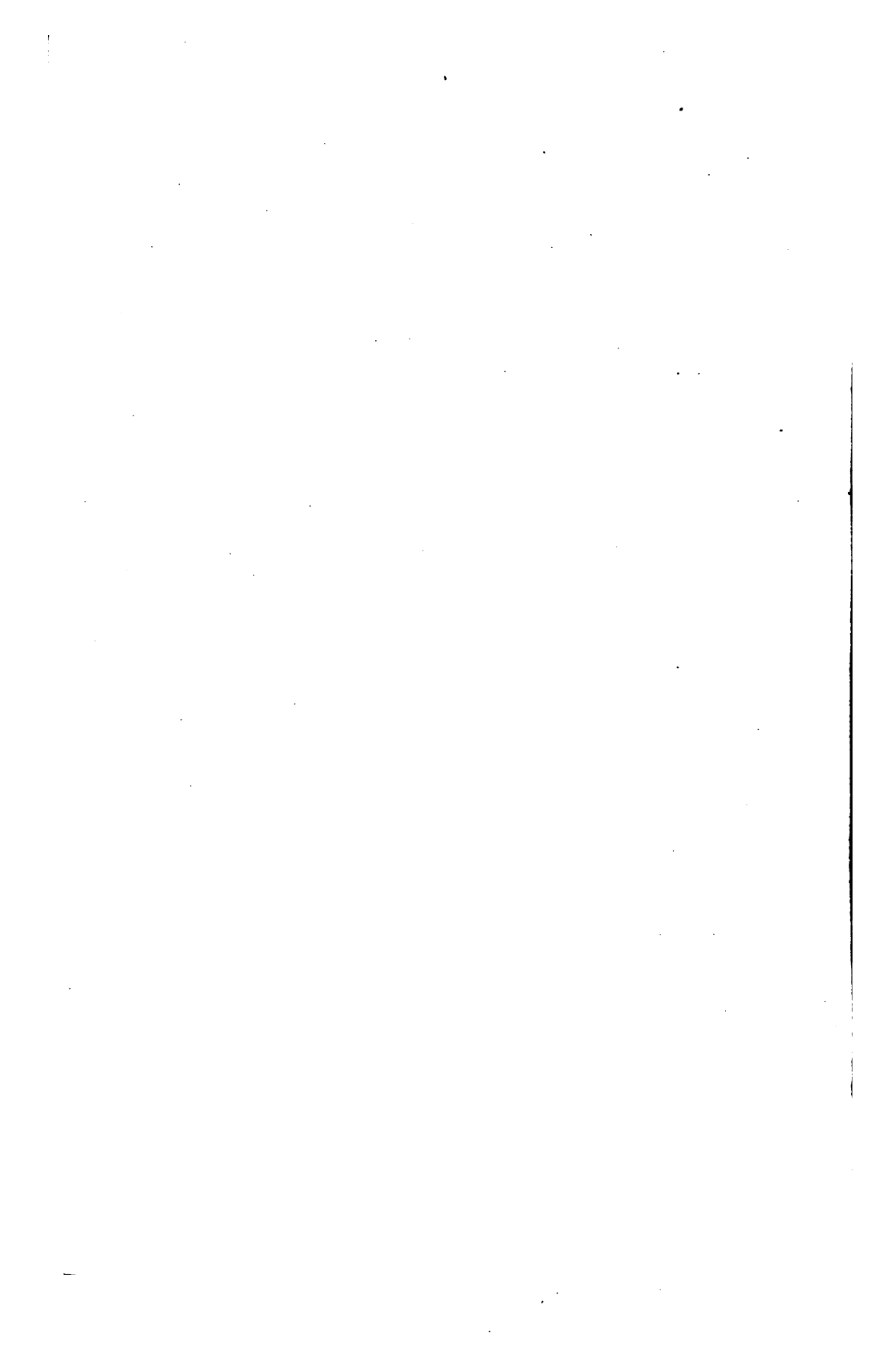


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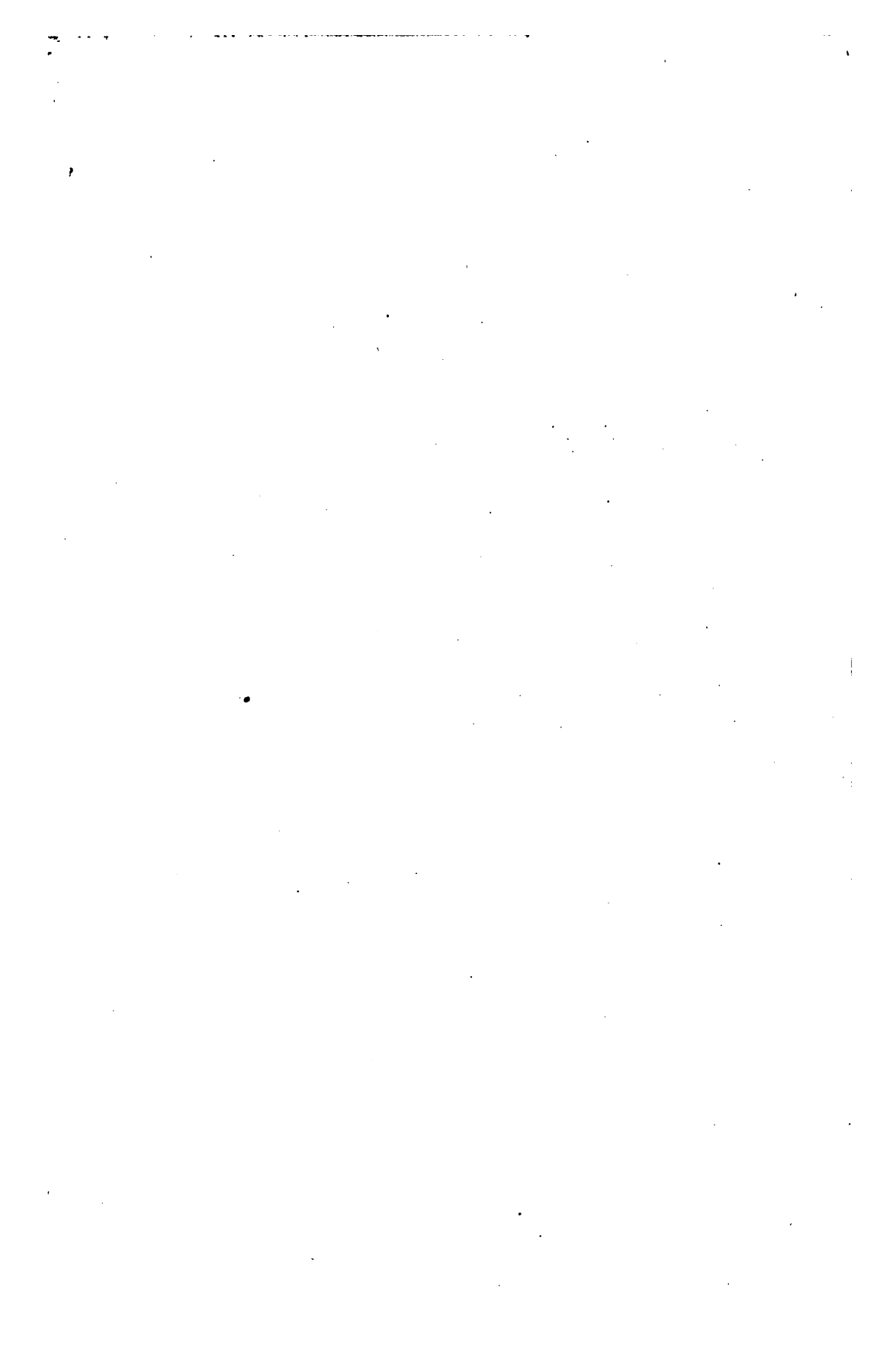
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